

MEDICAID WAIVER FOR OLDER ADULTS (WOA) PROGRAM

Billing and Reimbursement Reference Guide



April 2011

Table of Contents

Frequently Asked Questions	4
Assistive Devices and Equipment	7
Sample Claim Form for Assistive Devices and Equipment	8
Assisted Living Services	9
Sample Claim Forms for Assisted Living Services	10
Behavioral Consultation	12
Sample Claim Form for Behavioral Consultation	13
Diet and Nutritionist Services	14
Sample Claim Form for Diet and Nutritionist Services	15
Environmental Accessibility Adaptations	16
Sample Claim Form for Environmental Assessment	17
Environmental Assessment	18
Sample Claim Form for Environmental Assessment	19
Family or Consumer Training	20
Sample Claim Form for Family or Consumer Training	21
Home-Delivered Meals	22
Sample Claim Form for Home Delivered Meals	23
Personal Care Services	24
Self-employed Personal Care Aide - Non-Delegated (no medication administration)	24
Self-employed Personal Care Aide - Delegated (with medication administration)	24
Agency-employed Personal Care Aide – Non-Delegated (no medication administration)	25
Agency-employed personal Care Aide- Delegated (with medication administration)	26
Agency-employed Nurse Monitor	26
Sample Claim Forms for Personal Care Services	28
Personal Emergency Response Systems	30
Sample Claim Form for Personal Emergency Response System	31
Respite Care	32
Self-employed Respite Care Aide	32
Agency-employed Respite Care Aide	32
Respite Care in a Nursing Home	33
Respite Care in an Assisted Living Facility	34
Sample Claim Forms for Respite Care	35
Senior Center Plus	38
Sample Claim Form for Senior Center Plus	39
Appendix A	40

Appendix B.....42

Appendix C44

Appendix D 46

Appendix E48

WAIVER FOR OLDER ADULTS (WOA) PROGRAM

Billing and Reimbursement Reference Guide

Thank you for your participation as a provider in the Medicaid Waiver for Older Adults (WOA). These billing instructions are for the services covered under the Waiver for Older Adult and are intended to assist you to accurately prepare your claims for timely and accurate payments.

The Waiver program is governed by COMAR 10.09.54 (name the Comar citation) and by the federally approved waiver application. The Maryland Department of Health and Mental Hygiene (DHMH) is the State's lead agency for the Medicaid Program. Included among DHMH's responsibilities are enrolling waiver providers and processing and paying provider claims for waiver services. DHMH has delegated to the Maryland Department of Aging (MDoA) the responsibility for administering the waiver program through the Area Agencies on Aging (AAAs). Contact information for the AAAs can be found in Appendix E of these instructions.

General billing inquiries may be directed to Provider Relations, DHMH at 410-767-5503, or MDoA at 767 – 1118.

HOW IS A PROVIDER ASSIGNED A WAIVER PARTICIPANT?

- Requests for services will come from Area Agencies on Aging Case Managers based upon the participant assessed needs. Case Manager provides participants with a list of approved providers, generated by the Maryland Department of Aging (MDoA). The selected provider will be notified by the Case Manager;
- A copy of the participant's plan of care and pre-authorization forms if required will be forwarded to the selected provider. Services should not be rendered without an approved POC.

WHAT SHOULD I BE AWARE OF AS A PROVIDER?

- The recipient must be **enrolled** in the Waiver for Older Adults program as of the date of service.
- The **provider must be enrolled and approved** as a Medicaid Waiver provider of the **specific type** of service to be provided; authorized procedure codes identified in a letter from the Department of Health and Mental Hygiene (DHMH).
- Before rendering waiver services, the provider should contact the Area Agency of Aging for the participant, to confirm that the individual is enrolled in the Waiver for Older Adults and that the provider is approved in the recipient's plan of care to render the waiver service. A recipient's Medicaid eligibility should be verified prior to beginning service by calling the **Eligibility Verification System (EVS) at 410-333-3020 or 1- 800-492-2134**, 24 hours a day, 7 days a week. You must have the individual's Medicaid identification number.
- The waiver services must be rendered in accordance with the waiver participant's approved plan of care, COMAR 10.09.54, the State's waiver proposal, and any other applicable government requirements.
- The services must not exceed limitations or restrictions specified in the recipient's waiver plan of care or COMAR 10.09.54.
- Services covered by Medicaid (State Plan), Medicare, or another third party health insurance carrier are not reimbursable under the Medicaid Waiver for Older Adults. However, if the participant is enrolled in Medicaid, and is unable to pay the deductibles or co-pays associated with Medicare, (due to income limits), Medicaid will pay those co-payment(s) or deductible(s).
- To avoid later corrections or delays in payment, providers should check the accuracy of the information on the claim form before submission, particularly the provider's Medicaid number, the recipient's Medicaid number and billing codes. Note that claims forms must have original signatures and that Medicaid does not pay for services in advance.
- Providers are paid the lesser of their usual and customary charges to the general public, or the program rate established according to the methodology specified in COMAR 10.09.54.33 C.(3) – (18). Rate changes if any go into effect July 1 of each year and are communicated to providers by way of DHMH Transmittal.
- The program may not reimburse claims received for payment more than 12 months after the date of service. (Refer to DHMH Maryland Medical Assistance Program, General Provider Transmittal No. 71 for more details on this policy).

WHAT TYPE OF SERVICES ARE COVERED?

The following service types are covered under the Waiver:

Service Type	Procedure Codes for Billing Purposes
Assistive Devices	(W0214)
Assisted Living Services	(W0226, W0228, W0227 and W0229)
Behavioral Consultation Services	(W1724)
Dietician and Nutrition Services	(W0212)
Environmental Assessments	(W1725)
Environmental Accessibility Adaptations	(W0207)
Family or Consumer training	(W0208)
Home-delivered Meals	(W0211)
Personal Care (including Nurse Monitoring)	(W0200, W0201, W0202, W0203, and W0204)
Personal Emergency Response Systems	(W0209 and W0210)
Respite Care	(W0205, W0206, W0220, and W0221)
Senior Center Plus	(W1723)

WHERE DO I SEND COMPLETED CLAIM FORMS?

Claims for Waiver services should be submitted to the following address, unless you are otherwise notified by your local Area Agency on Aging:

ATTN: Waiver Billing
Maryland Department of Aging
301 W. Preston St., Suite 1007
Baltimore, Maryland, 21201

Please Note:

- a. Any Waiver billing forms for these services mistakenly sent to DHMH will be denied for payment. The claims will have to be re-done and re-submitted by the provider to the correct address, causing substantial delays in payment.**
- b. Claims containing errors or missing required information will be returned to the provider. The provider will be required to properly claim form and resubmit.**

Here are some common errors seen on claims. Claims with any of these errors will be returned:

Missing Provider Number (10 digit number beginning with 5)

Missing Recipient Medicaid Number (11 digit number)

Missing or incorrect rate

Missing Procedure Code

Missing Date of Service

Missing Units of Service

Missing Place of Service Code (33 for recipient's in Assisted Living; 12 for recipients receiving service at home)

- b. For providers of services requiring preauthorization, a signed preauthorization form must be obtained from the recipient's case manager. The preauthorization form must be attached to the claim form when the claim is submitted for payment. The Waiver services requiring preauthorization forms are:**

Environmental Accessibility Adaptation (W0207)

Assistive Devices and Equipment (W0214)

1500 Claim Form

[illegible]

<div style="display: flex; justify-content: space-between;"> <div> WAIVER FOR OLDER ADULT TRILLING CLAIM FORM <small>PATIENT'S MEDICAL HISTORY</small> </div> <div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; justify-content: space-between;"> <div> Participant's Name (Last, First, MI) <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> </div> <div> Address <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> City <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> </div> <div> State <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> </div> <div> Zip <div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> </div> </div> </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> <div style="display: flex; justify-content: space-between;"> <div> Participant Birth Date <div style="display: flex; justify-content: space-between;"> <div style="border-bottom: 1px solid black; width: 20%;"></div> <div style="border-bottom: 1px solid black; width: 20%;"></div> <div style="border-bottom: 1px solid black; width: 20%;"></div> <div style="border-bottom: 1px solid black; width: 20%;"></div> <div style="border-bottom: 1px solid black; width: 20%;"></div> </div> </div> <div> Participant's Sex <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Male <input type="checkbox"/> Female </div> </div> </div> </div> </div> </div></div>									
Date of Birth		Place of Birth		Uninsured Period per Date		Charges		Day Units	
MM	DD	YY	ADDR	POB					
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31

PROVIDER SIGNATURE

PROVIDER ADDRESS

CITY, STATE, ZIP

DATE

PROVIDER PHONE

TELEPHONE

TOTAL UNITS

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDA) and Area Agency on Aging (AAA) Claims Processors

MDA 6-27-07-FINAL

*MDoA will accept both types of claim forms. The Modified Billing Form is ONLY for paper claims submitted to MDoA or one of the six AAAs that process claims. DHMH will not process claims submitted on this form.

Specific Billing Instructions for Each Waiver Service

Assistive Devices and Equipment

Procedure Code	Services	Unit of Service	*Rate per Unit
W0214	Assistive Devices and Equipment	Single item	Cost of item (must have preauthorization)

The following are specific instructions for billing Assistive Devices And Equipment under the Waiver for Older Adults:

- Providers must be approved to provide Assistive Devices and Equipment Services under the Medicaid Waiver for Older Adults.
- A "unit of service" is defined as one item.
- Assistive Device or Equipment must be pre-authorized and documented in the participant's plan of care. Note: Items covered under their Medicaid State Plan Disposable Medical Supplies and Durable Medical Equipment Program (DMS/DME) must be billed to that program using their assigned State Plan Medicaid number. If you have questions, please contact DHMH's Division of Community Support Services (DCSS) at 410-767-1739. DCSS may require further information to determine if the item is covered under the DMS/DME program
- Requests for reimbursement must include a copy of the pre-authorization form and either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an original signature - NO FAXED COPIES ARE ACCEPTED.
- Assistive device and equipment must meet applicable standards of manufacturer, design, and installation.
- See COMAR 10.09.54.29 and DHMH Waiver Transmittal # 23 for additional information on this service.

Note: Waiver payments for assistive devices and equipment are capped at \$1,000 per participant over a 12-month period based on a calendar year (i.e. Assistive Device or Equipment provided 1/1/07; next eligibility date would be 1/02/08). **Exclusions include:** Eyeglasses, hearing aids and dentures.

Sample Claim for Assisted Devices and Equipment

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

1. MEDICARE <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other		2. PATIENT'S BIRTH DATE MM DD YY 01 22 29		3. INSURED'S NAME (Last, First, Middle Initial) Doe, John	
4. PATIENT'S ADDRESS (Home) 100 Center Street City: Baltimore, MD 21200		5. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. INSURED'S ADDRESS (Home) City: State: ZIP Code:	
7. OTHER INSURED DATA (Last Name, First Name, Middle Initial) 01234567890		8. EMPLOYMENT (Current or Past) YES <input type="checkbox"/> NO <input type="checkbox"/>		9. INSURED'S DATE OF BIRTH MM DD YY	
10. PATIENT'S SIGNATURE (Signature)		11. EMPLOYER'S NAME OR SCHOOL NAME (Name)		12. INSURED'S SIGNATURE (Signature)	
13. DATE OF SERVICE MM DD YY 12 12 07		14. PATIENT'S ACCOUNT NO. W0214		15. TOTAL CHARGE \$ 50.00	
16. SIGNATURE OF PHYSICIAN OR SUPPLIER (Signature)		17. SERVICE FACILITY LOCATION INFORMATION EYZ Agency 500 Mount Street Baltimore, MD		18. BALANCE OF DUE \$	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0333-0299 FORM CMB-1500 (08/05)

Assisted Living Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0226	Assistive Living Level II – no medical day care	Daily	\$55.71 per day
W0228	Assistive Living Level II – with medical day care	Daily	\$41.80 per day
W0227	Assistive Living Level III – no medical day care	Daily	\$70.29 per day
W0229	Assistive Living Level III – with medical day care	Daily	\$52.70 per day

Following are specific instructions for billing Assisted Living Services under the Waiver for Older Adults:

- Providers must be approved to provide Assisted Living Services under the Medicaid Waiver for Older Adults
- A "unit of service" for assisted living services is defined as one day
- Specific services to be provided are identified in COMAR 10.09.54.16.B(1 – 11)
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED The place of service for AL is code "33" meaning at ALF
- Daily rates are based on the participant's level of care and attendance at Adult Medical Care with pre-authorization.
- The service and provider must be identified in the participant's approved Plan of Care. A copy of the participant's plan of care must be kept on file
- Assisted living charges paid by the Medicaid Waiver do **not** include room and board. The waiver participant is expected to pay the provider's charge for room and board, which may not exceed \$420 per month for a waiver participant. In addition, Waiver rules require that a participant with income over a certain level must make monthly payments toward the cost of their assisted living services. The monthly amount that must be paid to the ALF provider by the participant is called the "contribution to care" (CTC). The amount Medicaid pays the ALF provider is reduced by the amount of the participant's monthly CTC. The monthly CTC amount paid to the provider by the participant is in addition to the amount (up to \$420 a month) a participant must pay for room and board. See Waiver Transmittal #21 for additional information on CTC.
- The provider may not bill for any days during the month that the participant was not eligible for the waiver or was not considered to be residing in the facility because the participant:
 - moved out of the provider's facility;
 - Had not yet moved into the provider's facility;
 - was an inpatient for one or more nights at a hospital, nursing facility, or other medical institution; or
 - was absent from the provider's facility for more than seven (7) nights during a calendar month at the participant's choice for personal reasons, (i.e., family visit or vacation).
- Claims may only be submitted after the end of the month of service.

Note: As part of the provider agreement, an assisted living facility agrees to accept the combination of funds paid by Medicaid and the participant (room and board + CTC) as **payment in full**.

IMPORTANT

ASSISTED LIVING SERVICE PROVIDERS THAT DIRECTLY BILL DHMH MUST USE THE CMS 1500 CLAIM FORM (Appendix D). USE OF OTHER CLAIM FORMS WILL RESULT IN REJECTION OF CLAIMS.

Sample Claim for Assisted Living Services Level III with 3 Day of Medical Day Care Per Week

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> PRIVATE INSURANCE (Private Insurance) <input type="checkbox"/> OTHER (Other) <input type="checkbox"/>		2. INSURED'S ID NUMBER (For Payment in Item 1)	
3. PATIENT'S NAME (Last, First, Middle Initial) Doe, John		4. INSURED'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (Street) 100 Center Street		6. INSURED'S ADDRESS (Street)	
7. CITY Baltimore, MD		8. STATE MD	
9. ZIP CODE 21209		10. TELEPHONE (Include Area Code) (410) 333-3333	
11. OTHER INSURED HAVE (Last Name, First Name, Middle Initial)		12. INSURED'S POLICY GROUP OR PROGRAM NUMBER K	
13. EMPLOYER'S NAME OR PROGRAM NAME 01234567890		14. INSURED'S DATE OF BIRTH MM DD YY	
15. OTHER EMPLOYER'S NAME OR PROGRAM NAME		16. EMPLOYER'S NAME OR SCHOOL NAME	
17. INSURANCE PLAN NAME OR PROGRAM NAME		18. IS THERE ANOTHER HEALTH BENEFIT PLAN YES <input type="checkbox"/> NO <input type="checkbox"/>	
19. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 20. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicates the release of any medical or other information necessary to process this claim. It also requests payment of government benefits when it is equal to the party who accepts assignment below.) SIGNED: _____ DATE: _____			
21. DATE OF CURRENT CLAIM MM DD YY		22. DATE OF NEXT CLAIM MM DD YY	
23. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		24. DATE OF REFERRAL MM DD YY	
25. RESERVED FOR LOCAL USE		26. DATE OF REFERRAL MM DD YY	
27. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		28. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
29. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		30. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
31. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		32. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
33. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		34. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
35. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		36. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
37. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		38. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
39. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		40. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
41. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		42. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
43. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		44. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
45. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		46. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
47. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		48. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
49. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		50. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
51. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		52. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
53. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		54. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
55. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		56. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
57. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		58. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
59. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		60. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
61. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		62. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
63. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		64. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
65. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		66. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
67. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		68. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
69. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		70. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
71. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		72. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
73. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		74. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
75. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		76. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
77. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		78. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
79. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		80. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
81. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		82. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
83. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		84. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
85. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		86. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
87. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		88. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
89. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		90. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
91. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		92. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
93. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		94. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
95. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		96. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
97. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		98. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	
99. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)		100. PHYSICIAN'S OR PATIENT'S SIGNATURE (Last Name, First Name, Middle Initial)	

NUCC Instructions Manual available at: www.nucc.org

APPROVED CMB-0333-0309 FORM CMS-1500 (08/03)

Sample Claim for Assisted Living Level II with 5 Days of Medical Day Care Per Week

WAIVER FOR OLDER ADULT BILLING CLAIM FORM <small>**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging</small>																																																																																																																																																																																																																																																																																																																																																																																				
Participant's Name: John Doe				Participant's Medicaid Number																																																																																																																																																																																																																																																																																																																																																																																
Address: 100 Center Street				<table border="1"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>0</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>								0	1	2	3	4	5	6	7	8	9	0																																																																																																																																																																																																																																																																																																																																																														
0	1	2	3	4	5	6	7	8	9	0																																																																																																																																																																																																																																																																																																																																																																										
City: Baltimore		State: Maryland		Participant Birth Date			Insurance Policy Group		Participant Sex																																																																																																																																																																																																																																																																																																																																																																											
Zip: 21200		Telephone: 410-333-3333		<table border="1"> <tr> <td>MM</td><td>DD</td><td>YYYY</td> </tr> <tr> <td>1</td><td>22</td><td>1929</td> </tr> </table>			MM	DD	YYYY	1	22	1929	K		<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female																																																																																																																																																																																																																																																																																																																																																																					
MM	DD	YYYY																																																																																																																																																																																																																																																																																																																																																																																		
1	22	1929																																																																																																																																																																																																																																																																																																																																																																																		
<table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">Dates Billed</th> <th colspan="2">Place of Service</th> <th rowspan="2">Waiver Procedure Code</th> <th colspan="2">Charges</th> <th colspan="2">Day/Units</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>ALP-13</th> <th>PC-12</th> <th></th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr><td>1</td><td>01</td><td>01</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>01</td><td>02</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>2</td></tr> <tr><td>3</td><td>01</td><td>03</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>3</td></tr> <tr><td>4</td><td></td><td>04</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>4</td></tr> <tr><td>5</td><td>01</td><td>05</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>5</td></tr> <tr><td>6</td><td>01</td><td>06</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>6</td></tr> <tr><td>7</td><td>01</td><td>07</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>7</td></tr> <tr><td>8</td><td>01</td><td>08</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>8</td></tr> <tr><td>9</td><td>01</td><td>09</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>9</td></tr> <tr><td>10</td><td>01</td><td>10</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>10</td></tr> <tr><td>11</td><td>01</td><td>11</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>11</td></tr> <tr><td>12</td><td>01</td><td>12</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>12</td></tr> <tr><td>13</td><td>01</td><td>13</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>13</td></tr> <tr><td>14</td><td>01</td><td>14</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>14</td></tr> <tr><td>15</td><td>01</td><td>15</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>15</td></tr> <tr><td>16</td><td>01</td><td>16</td><td>03</td><td>23</td><td></td><td>In hospital</td><td>0</td><td>0</td><td>1</td><td>16</td></tr> <tr><td>17</td><td>01</td><td>17</td><td>03</td><td>23</td><td></td><td>In hospital</td><td>0</td><td>0</td><td>1</td><td>17</td></tr> <tr><td>18</td><td>01</td><td>18</td><td>03</td><td>23</td><td></td><td>In hospital</td><td>0</td><td>0</td><td>1</td><td>18</td></tr> <tr><td>19</td><td>01</td><td>19</td><td>03</td><td>23</td><td></td><td>In hospital</td><td>0</td><td>0</td><td>1</td><td>19</td></tr> <tr><td>20</td><td>01</td><td>20</td><td>03</td><td>23</td><td></td><td>In hospital</td><td>0</td><td>0</td><td>1</td><td>20</td></tr> <tr><td>21</td><td>01</td><td>21</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>21</td></tr> <tr><td>22</td><td>01</td><td>22</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>22</td></tr> <tr><td>23</td><td>01</td><td>23</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>23</td></tr> <tr><td>24</td><td>01</td><td>24</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>24</td></tr> <tr><td>25</td><td>01</td><td>25</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>25</td></tr> <tr><td>26</td><td>01</td><td>26</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>26</td></tr> <tr><td>27</td><td>01</td><td>27</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>27</td></tr> <tr><td>28</td><td>01</td><td>28</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>28</td></tr> <tr><td>29</td><td>01</td><td>29</td><td>03</td><td>23</td><td></td><td>W0223</td><td>59</td><td>53</td><td>1</td><td>29</td></tr> <tr><td>30</td><td>01</td><td>30</td><td>03</td><td>23</td><td></td><td>W0223</td><td>42</td><td>44</td><td>1</td><td>30</td></tr> <tr><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>31</td></tr> </tbody> </table>													Dates Billed			Place of Service		Waiver Procedure Code	Charges		Day/Units		MM	DD	YY	ALP-13	PC-12					1	01	01	03	23		W0223	59	53	1	1	2	01	02	03	23		W0223	42	44	1	2	3	01	03	03	23		W0223	42	44	1	3	4		04	03	23		W0223	42	44	1	4	5	01	05	03	23		W0223	42	44	1	5	6	01	06	03	23		W0223	42	44	1	6	7	01	07	03	23		W0223	59	53	1	7	8	01	08	03	23		W0223	59	53	1	8	9	01	09	03	23		W0223	42	44	1	9	10	01	10	03	23		W0223	42	44	1	10	11	01	11	03	23		W0223	42	44	1	11	12	01	12	03	23		W0223	42	44	1	12	13	01	13	03	23		W0223	42	44	1	13	14	01	14	03	23		W0223	59	53	1	14	15	01	15	03	23		W0223	59	53	1	15	16	01	16	03	23		In hospital	0	0	1	16	17	01	17	03	23		In hospital	0	0	1	17	18	01	18	03	23		In hospital	0	0	1	18	19	01	19	03	23		In hospital	0	0	1	19	20	01	20	03	23		In hospital	0	0	1	20	21	01	21	03	23		W0223	59	53	1	21	22	01	22	03	23		W0223	59	53	1	22	23	01	23	03	23		W0223	42	44	1	23	24	01	24	03	23		W0223	42	44	1	24	25	01	25	03	23		W0223	42	44	1	25	26	01	26	03	23		W0223	42	44	1	26	27	01	27	03	23		W0223	42	44	1	27	28	01	28	03	23		W0223	59	53	1	28	29	01	29	03	23		W0223	59	53	1	29	30	01	30	03	23		W0223	42	44	1	30	31										31
	Dates Billed			Place of Service		Waiver Procedure Code	Charges		Day/Units																																																																																																																																																																																																																																																																																																																																																																											
	MM	DD	YY	ALP-13	PC-12																																																																																																																																																																																																																																																																																																																																																																															
1	01	01	03	23		W0223	59	53	1	1																																																																																																																																																																																																																																																																																																																																																																										
2	01	02	03	23		W0223	42	44	1	2																																																																																																																																																																																																																																																																																																																																																																										
3	01	03	03	23		W0223	42	44	1	3																																																																																																																																																																																																																																																																																																																																																																										
4		04	03	23		W0223	42	44	1	4																																																																																																																																																																																																																																																																																																																																																																										
5	01	05	03	23		W0223	42	44	1	5																																																																																																																																																																																																																																																																																																																																																																										
6	01	06	03	23		W0223	42	44	1	6																																																																																																																																																																																																																																																																																																																																																																										
7	01	07	03	23		W0223	59	53	1	7																																																																																																																																																																																																																																																																																																																																																																										
8	01	08	03	23		W0223	59	53	1	8																																																																																																																																																																																																																																																																																																																																																																										
9	01	09	03	23		W0223	42	44	1	9																																																																																																																																																																																																																																																																																																																																																																										
10	01	10	03	23		W0223	42	44	1	10																																																																																																																																																																																																																																																																																																																																																																										
11	01	11	03	23		W0223	42	44	1	11																																																																																																																																																																																																																																																																																																																																																																										
12	01	12	03	23		W0223	42	44	1	12																																																																																																																																																																																																																																																																																																																																																																										
13	01	13	03	23		W0223	42	44	1	13																																																																																																																																																																																																																																																																																																																																																																										
14	01	14	03	23		W0223	59	53	1	14																																																																																																																																																																																																																																																																																																																																																																										
15	01	15	03	23		W0223	59	53	1	15																																																																																																																																																																																																																																																																																																																																																																										
16	01	16	03	23		In hospital	0	0	1	16																																																																																																																																																																																																																																																																																																																																																																										
17	01	17	03	23		In hospital	0	0	1	17																																																																																																																																																																																																																																																																																																																																																																										
18	01	18	03	23		In hospital	0	0	1	18																																																																																																																																																																																																																																																																																																																																																																										
19	01	19	03	23		In hospital	0	0	1	19																																																																																																																																																																																																																																																																																																																																																																										
20	01	20	03	23		In hospital	0	0	1	20																																																																																																																																																																																																																																																																																																																																																																										
21	01	21	03	23		W0223	59	53	1	21																																																																																																																																																																																																																																																																																																																																																																										
22	01	22	03	23		W0223	59	53	1	22																																																																																																																																																																																																																																																																																																																																																																										
23	01	23	03	23		W0223	42	44	1	23																																																																																																																																																																																																																																																																																																																																																																										
24	01	24	03	23		W0223	42	44	1	24																																																																																																																																																																																																																																																																																																																																																																										
25	01	25	03	23		W0223	42	44	1	25																																																																																																																																																																																																																																																																																																																																																																										
26	01	26	03	23		W0223	42	44	1	26																																																																																																																																																																																																																																																																																																																																																																										
27	01	27	03	23		W0223	42	44	1	27																																																																																																																																																																																																																																																																																																																																																																										
28	01	28	03	23		W0223	59	53	1	28																																																																																																																																																																																																																																																																																																																																																																										
29	01	29	03	23		W0223	59	53	1	29																																																																																																																																																																																																																																																																																																																																																																										
30	01	30	03	23		W0223	42	44	1	30																																																																																																																																																																																																																																																																																																																																																																										
31										31																																																																																																																																																																																																																																																																																																																																																																										
Your Original Signature PROVIDER SIGNATURE				PROVIDER/FACILITY NAME: AEC AGENCY 600 MOUNT STREET PROVIDER ADDRESS				\$ 1188.25 TOTAL AMOUNT		TOTAL UNITS																																																																																																																																																																																																																																																																																																																																																																										
DATE				CITY, STATE, ZIP: BALTIMORE, MD, 21200				TELEPHONE: 410-333-3333																																																																																																																																																																																																																																																																																																																																																																												
PROVIDER#				<table border="1"> <tr> <td>5</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td> </tr> </table>								5	9	9	9	9	9	9	9	9	9	9																																																																																																																																																																																																																																																																																																																																																														
5	9	9	9	9	9	9	9	9	9	9																																																																																																																																																																																																																																																																																																																																																																										

(AAA) Claims Processors MDOA/6-37-07- FINAL

Behavior Consultation Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W1724	Behavior Consultation	1 hour	\$60.93 per hour

Following are specific instructions for billing Behavior Consultation services under the Waiver for Older Adults.

- Providers must be approved to provide Behavior Consultation Services under the Medicaid Waiver for Older Adults.
- The service and provider must be identified in the participant's approved Plan of Care
- A "unit of service" is one hour (no partial hour increments are accepted)
- Services may be provided to waiver participants residing either at home or in an assisted living facility.
- The provider must:
 - respond within 24 hours after receiving a referral
 - evaluate the waiver participant's acute behavior change, assess the situation, determine the contributing factors, and recommend interventions and treatments;
 - Verbally review the report with the Case Manager (CM) and either the family or assisted living provider to discuss the report's findings and recommendations and a course of action, including any related needed medical interventions.
 - Submit a written report to the case manager and to either the family or assisted living provider, which assesses the situation and makes recommendations
 - Claims are to be submitted for services rendered by a qualified individual during a home visit and not for time spent on related activities before or after the visit . See COMAR 10.09.54.20 for additional information on reimbursement for this service. .
 - Medicaid will pay the provider the lesser of \$62.17\$ per unit of service or the provider's usual and customary charge for the general public.
 - Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an original signature - NO FAXED COPIES ARE ACCEPTED

Sample Claim For Behavior Consultation

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 03/95

<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> GROUP PLAN <input type="checkbox"/> OTHER		1. INSURED'S I.D. NUMBER (For Paper Claim) 2. INSURED'S NAME (Last Name, First Name, Middle Initial) 3. INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)	
4. PATIENT'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Area Code)		6. PATIENT'S RELATIONSHIP TO INSURED 7. PATIENT'S STATUS 8. PATIENT'S DATE OF BIRTH 9. PATIENT'S SEX	
10. OTHER INSURED POLICY GROUP OR PROGRAM NAME 11. EMPLOYER'S NAME OR SCHOOL NAME 12. INSURANCE PLAN NAME OR PROGRAM NAME		13. IS THERE ANOTHER HEALTH BENEFIT PLAN? 14. DATE OF CURRENT PLAN 15. NAME OF REFERRING PROVIDER OR OTHER SOURCE 16. RESERVED FOR LOCAL USE	
17. DATE OF CURRENT PLAN 18. NAME OF REFERRING PROVIDER OR OTHER SOURCE 19. RESERVED FOR LOCAL USE		20. DATE OF CURRENT PLAN 21. NAME OF REFERRING PROVIDER OR OTHER SOURCE 22. RESERVED FOR LOCAL USE	
23. DATE OF CURRENT PLAN 24. NAME OF REFERRING PROVIDER OR OTHER SOURCE 25. RESERVED FOR LOCAL USE		26. DATE OF CURRENT PLAN 27. NAME OF REFERRING PROVIDER OR OTHER SOURCE 28. RESERVED FOR LOCAL USE	
29. DATE OF CURRENT PLAN 30. NAME OF REFERRING PROVIDER OR OTHER SOURCE 31. RESERVED FOR LOCAL USE		32. DATE OF CURRENT PLAN 33. NAME OF REFERRING PROVIDER OR OTHER SOURCE 34. RESERVED FOR LOCAL USE	
35. DATE OF CURRENT PLAN 36. NAME OF REFERRING PROVIDER OR OTHER SOURCE 37. RESERVED FOR LOCAL USE		38. DATE OF CURRENT PLAN 39. NAME OF REFERRING PROVIDER OR OTHER SOURCE 40. RESERVED FOR LOCAL USE	
41. DATE OF CURRENT PLAN 42. NAME OF REFERRING PROVIDER OR OTHER SOURCE 43. RESERVED FOR LOCAL USE		44. DATE OF CURRENT PLAN 45. NAME OF REFERRING PROVIDER OR OTHER SOURCE 46. RESERVED FOR LOCAL USE	
47. DATE OF CURRENT PLAN 48. NAME OF REFERRING PROVIDER OR OTHER SOURCE 49. RESERVED FOR LOCAL USE		50. DATE OF CURRENT PLAN 51. NAME OF REFERRING PROVIDER OR OTHER SOURCE 52. RESERVED FOR LOCAL USE	
53. DATE OF CURRENT PLAN 54. NAME OF REFERRING PROVIDER OR OTHER SOURCE 55. RESERVED FOR LOCAL USE		56. DATE OF CURRENT PLAN 57. NAME OF REFERRING PROVIDER OR OTHER SOURCE 58. RESERVED FOR LOCAL USE	
59. DATE OF CURRENT PLAN 60. NAME OF REFERRING PROVIDER OR OTHER SOURCE 61. RESERVED FOR LOCAL USE		62. DATE OF CURRENT PLAN 63. NAME OF REFERRING PROVIDER OR OTHER SOURCE 64. RESERVED FOR LOCAL USE	
65. DATE OF CURRENT PLAN 66. NAME OF REFERRING PROVIDER OR OTHER SOURCE 67. RESERVED FOR LOCAL USE		68. DATE OF CURRENT PLAN 69. NAME OF REFERRING PROVIDER OR OTHER SOURCE 70. RESERVED FOR LOCAL USE	
71. DATE OF CURRENT PLAN 72. NAME OF REFERRING PROVIDER OR OTHER SOURCE 73. RESERVED FOR LOCAL USE		74. DATE OF CURRENT PLAN 75. NAME OF REFERRING PROVIDER OR OTHER SOURCE 76. RESERVED FOR LOCAL USE	
77. DATE OF CURRENT PLAN 78. NAME OF REFERRING PROVIDER OR OTHER SOURCE 79. RESERVED FOR LOCAL USE		80. DATE OF CURRENT PLAN 81. NAME OF REFERRING PROVIDER OR OTHER SOURCE 82. RESERVED FOR LOCAL USE	
83. DATE OF CURRENT PLAN 84. NAME OF REFERRING PROVIDER OR OTHER SOURCE 85. RESERVED FOR LOCAL USE		86. DATE OF CURRENT PLAN 87. NAME OF REFERRING PROVIDER OR OTHER SOURCE 88. RESERVED FOR LOCAL USE	
89. DATE OF CURRENT PLAN 90. NAME OF REFERRING PROVIDER OR OTHER SOURCE 91. RESERVED FOR LOCAL USE		92. DATE OF CURRENT PLAN 93. NAME OF REFERRING PROVIDER OR OTHER SOURCE 94. RESERVED FOR LOCAL USE	
95. DATE OF CURRENT PLAN 96. NAME OF REFERRING PROVIDER OR OTHER SOURCE 97. RESERVED FOR LOCAL USE		98. DATE OF CURRENT PLAN 99. NAME OF REFERRING PROVIDER OR OTHER SOURCE 100. RESERVED FOR LOCAL USE	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0333-0399 FORM CMS-1500 (03/03)

Dietitian and Nutritionist Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0212	Dietitian or Nutritionist Service	1 hour	\$60.93 per hour

Following are specific instructions for billing Dietitian or Nutritionist Services under the Waiver for Older

- Adults Providers must be approved to provide Dietitian and Nutritionist Services under the Medicaid Waiver for Older Adults
- A "unit of service" for Dietitian and Nutritionist Services is one hour of covered services provided during or in conjunction with a home visit with the waiver participant.
- This service and provider must be listed in the participant's approved Plan of Care
- Services must be:
 - Delivered one-on-one, and may not be rendered on a group basis or in a classroom setting.
 - Provided to in-home participants only
- Other third party insurances should be billed prior to billing the Medicaid Waiver.
- See COMAR 10.09.54.28 for additional information on reimbursement for this service
- Medicaid will pay the provider the lesser of: \$62.17 per unit of service or the provider's usual and customary charge
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an original signature - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Dietitian and Nutrition Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PRIVATE GROUP <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> OTHER		<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PRIVATE GROUP <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> OTHER	
1. PATIENT'S NAME (Last, First, Middle Initial) Doe, John		2. PATIENT'S DATE OF BIRTH 01/22/29	
3. PATIENT'S ADDRESS (No. & Street) 100 Center Street		4. INSURED'S NAME (Last, First, Middle Initial) Doe, John	
5. PATIENT'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		6. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200	
7. OTHER INSURED'S NAME (Last, First, Middle Initial) Doe, Jane		8. PATIENT'S STATUS <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
9. OTHER INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		10. PATIENT'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
11. INSURED'S POLICY GROUP OR PROGRAM NAME K		12. INSURED'S DATE OF BIRTH 01/22/29	
13. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		14. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
15. INSURED'S POLICY GROUP OR PROGRAM NAME K		16. INSURED'S DATE OF BIRTH 01/22/29	
17. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		18. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
19. INSURED'S POLICY GROUP OR PROGRAM NAME K		20. INSURED'S DATE OF BIRTH 01/22/29	
21. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		22. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
23. INSURED'S POLICY GROUP OR PROGRAM NAME K		24. INSURED'S DATE OF BIRTH 01/22/29	
25. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		26. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
27. INSURED'S POLICY GROUP OR PROGRAM NAME K		28. INSURED'S DATE OF BIRTH 01/22/29	
29. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		30. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
31. INSURED'S POLICY GROUP OR PROGRAM NAME K		32. INSURED'S DATE OF BIRTH 01/22/29	
33. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		34. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
35. INSURED'S POLICY GROUP OR PROGRAM NAME K		36. INSURED'S DATE OF BIRTH 01/22/29	
37. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		38. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
39. INSURED'S POLICY GROUP OR PROGRAM NAME K		40. INSURED'S DATE OF BIRTH 01/22/29	
41. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		42. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
43. INSURED'S POLICY GROUP OR PROGRAM NAME K		44. INSURED'S DATE OF BIRTH 01/22/29	
45. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		46. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
47. INSURED'S POLICY GROUP OR PROGRAM NAME K		48. INSURED'S DATE OF BIRTH 01/22/29	
49. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		50. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
51. INSURED'S POLICY GROUP OR PROGRAM NAME K		52. INSURED'S DATE OF BIRTH 01/22/29	
53. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		54. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
55. INSURED'S POLICY GROUP OR PROGRAM NAME K		56. INSURED'S DATE OF BIRTH 01/22/29	
57. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		58. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
59. INSURED'S POLICY GROUP OR PROGRAM NAME K		60. INSURED'S DATE OF BIRTH 01/22/29	
61. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		62. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
63. INSURED'S POLICY GROUP OR PROGRAM NAME K		64. INSURED'S DATE OF BIRTH 01/22/29	
65. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		66. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
67. INSURED'S POLICY GROUP OR PROGRAM NAME K		68. INSURED'S DATE OF BIRTH 01/22/29	
69. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		70. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
71. INSURED'S POLICY GROUP OR PROGRAM NAME K		72. INSURED'S DATE OF BIRTH 01/22/29	
73. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		74. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
75. INSURED'S POLICY GROUP OR PROGRAM NAME K		76. INSURED'S DATE OF BIRTH 01/22/29	
77. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		78. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
79. INSURED'S POLICY GROUP OR PROGRAM NAME K		80. INSURED'S DATE OF BIRTH 01/22/29	
81. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		82. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
83. INSURED'S POLICY GROUP OR PROGRAM NAME K		84. INSURED'S DATE OF BIRTH 01/22/29	
85. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		86. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
87. INSURED'S POLICY GROUP OR PROGRAM NAME K		88. INSURED'S DATE OF BIRTH 01/22/29	
89. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		90. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
91. INSURED'S POLICY GROUP OR PROGRAM NAME K		92. INSURED'S DATE OF BIRTH 01/22/29	
93. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		94. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
95. INSURED'S POLICY GROUP OR PROGRAM NAME K		96. INSURED'S DATE OF BIRTH 01/22/29	
97. INSURED'S ADDRESS (City, State, ZIP) Baltimore, MD 21200		98. INSURED'S EMPLOYMENT STATUS <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
99. INSURED'S POLICY GROUP OR PROGRAM NAME K		100. INSURED'S DATE OF BIRTH 01/22/29	

Environmental Accessibility Adaptations

Procedure Code	Services	Unit of Service	*Rate per Unit
W0207	Environmental Accessibility Adaptations	One or more physical adaptations to a participant's home	Based on bid – not to exceed \$5,000 per year or \$10,000 in the participants lifetime

Following are specific instructions for billing Environmental Accessibility Adaptations under the Waiver for Older Adults:

- Providers must be approved to provide Environmental Accessibility Adaptations Services under the Medicaid Waiver for Older Adults
- A "unit of service" is defined as one or more physical adaptations to the waiver participant's residence, completed as one job.
- This service and provider must be listed in the participant's approved Plan of Care. In addition, a Pre-authorization Form completed by participant's CM is required.
- Services must be preauthorized and receive final approval from the Case Manager as well as the owner of the home or building (when the owner is not the waiver participant) prior to starting the adaptations.
- Work must be performed in accordance with State and local building codes; and the appropriate inspections, permits, and approvals must be obtained. See COMAR 10.09.54.08 & .24 and DHMH Waiver Transmittal # 23 for additional information on reimbursement for this service.
- Requests for reimbursement must include a copy of the pre-authorization form and either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an **original signature**
- NO FAXED COPIES ARE ACCEPTED.

Sample Claim for Environmental Accessibility Adaptations

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 02/85

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/>		2. INSURED'S I.D. NUMBER (For Page 1 & Form 1)	
3. PATIENT'S NAME (Last, First, Middle Initial) Doe, John		4. INSURED'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (No. & Street) 100 Center Street		6. INSURED'S ADDRESS (No. & Street)	
7. CITY Baltimore, MD		8. STATE	
9. ZIP CODE 21209		10. TELEPHONE (Area Code) (410) 333-3333	
11. OTHER INSURED'S NAME (Last, First, Middle Initial)		12. INSURED'S POLICY GROUP OR IDENTIFICATION NUMBER K	
13. OTHER INSURED'S DATE OF BIRTH 01/22/29		14. INSURED'S DATE OF BIRTH MM DD YY	
15. OTHER INSURED'S SEX M		16. INSURED'S SEX M	
17. EMPLOYER'S NAME OR SCHOOL NAME		18. EMPLOYER'S NAME OR SCHOOL NAME	
19. EMPLOYER'S NAME OR PROGRAM NAME		20. EMPLOYER'S NAME OR PROGRAM NAME	
21. EMPLOYER'S NAME OR PROGRAM NAME		22. EMPLOYER'S NAME OR PROGRAM NAME	
23. EMPLOYER'S NAME OR PROGRAM NAME		24. EMPLOYER'S NAME OR PROGRAM NAME	
25. EMPLOYER'S NAME OR PROGRAM NAME		26. EMPLOYER'S NAME OR PROGRAM NAME	
27. EMPLOYER'S NAME OR PROGRAM NAME		28. EMPLOYER'S NAME OR PROGRAM NAME	
29. EMPLOYER'S NAME OR PROGRAM NAME		30. EMPLOYER'S NAME OR PROGRAM NAME	
31. EMPLOYER'S NAME OR PROGRAM NAME		32. EMPLOYER'S NAME OR PROGRAM NAME	
33. EMPLOYER'S NAME OR PROGRAM NAME		34. EMPLOYER'S NAME OR PROGRAM NAME	
35. EMPLOYER'S NAME OR PROGRAM NAME		36. EMPLOYER'S NAME OR PROGRAM NAME	
37. EMPLOYER'S NAME OR PROGRAM NAME		38. EMPLOYER'S NAME OR PROGRAM NAME	
39. EMPLOYER'S NAME OR PROGRAM NAME		40. EMPLOYER'S NAME OR PROGRAM NAME	
41. EMPLOYER'S NAME OR PROGRAM NAME		42. EMPLOYER'S NAME OR PROGRAM NAME	
43. EMPLOYER'S NAME OR PROGRAM NAME		44. EMPLOYER'S NAME OR PROGRAM NAME	
45. EMPLOYER'S NAME OR PROGRAM NAME		46. EMPLOYER'S NAME OR PROGRAM NAME	
47. EMPLOYER'S NAME OR PROGRAM NAME		48. EMPLOYER'S NAME OR PROGRAM NAME	
49. EMPLOYER'S NAME OR PROGRAM NAME		50. EMPLOYER'S NAME OR PROGRAM NAME	
51. EMPLOYER'S NAME OR PROGRAM NAME		52. EMPLOYER'S NAME OR PROGRAM NAME	
53. EMPLOYER'S NAME OR PROGRAM NAME		54. EMPLOYER'S NAME OR PROGRAM NAME	
55. EMPLOYER'S NAME OR PROGRAM NAME		56. EMPLOYER'S NAME OR PROGRAM NAME	
57. EMPLOYER'S NAME OR PROGRAM NAME		58. EMPLOYER'S NAME OR PROGRAM NAME	
59. EMPLOYER'S NAME OR PROGRAM NAME		60. EMPLOYER'S NAME OR PROGRAM NAME	
61. EMPLOYER'S NAME OR PROGRAM NAME		62. EMPLOYER'S NAME OR PROGRAM NAME	
63. EMPLOYER'S NAME OR PROGRAM NAME		64. EMPLOYER'S NAME OR PROGRAM NAME	
65. EMPLOYER'S NAME OR PROGRAM NAME		66. EMPLOYER'S NAME OR PROGRAM NAME	
67. EMPLOYER'S NAME OR PROGRAM NAME		68. EMPLOYER'S NAME OR PROGRAM NAME	
69. EMPLOYER'S NAME OR PROGRAM NAME		70. EMPLOYER'S NAME OR PROGRAM NAME	
71. EMPLOYER'S NAME OR PROGRAM NAME		72. EMPLOYER'S NAME OR PROGRAM NAME	
73. EMPLOYER'S NAME OR PROGRAM NAME		74. EMPLOYER'S NAME OR PROGRAM NAME	
75. EMPLOYER'S NAME OR PROGRAM NAME		76. EMPLOYER'S NAME OR PROGRAM NAME	
77. EMPLOYER'S NAME OR PROGRAM NAME		78. EMPLOYER'S NAME OR PROGRAM NAME	
79. EMPLOYER'S NAME OR PROGRAM NAME		80. EMPLOYER'S NAME OR PROGRAM NAME	
81. EMPLOYER'S NAME OR PROGRAM NAME		82. EMPLOYER'S NAME OR PROGRAM NAME	
83. EMPLOYER'S NAME OR PROGRAM NAME		84. EMPLOYER'S NAME OR PROGRAM NAME	
85. EMPLOYER'S NAME OR PROGRAM NAME		86. EMPLOYER'S NAME OR PROGRAM NAME	
87. EMPLOYER'S NAME OR PROGRAM NAME		88. EMPLOYER'S NAME OR PROGRAM NAME	
89. EMPLOYER'S NAME OR PROGRAM NAME		90. EMPLOYER'S NAME OR PROGRAM NAME	
91. EMPLOYER'S NAME OR PROGRAM NAME		92. EMPLOYER'S NAME OR PROGRAM NAME	
93. EMPLOYER'S NAME OR PROGRAM NAME		94. EMPLOYER'S NAME OR PROGRAM NAME	
95. EMPLOYER'S NAME OR PROGRAM NAME		96. EMPLOYER'S NAME OR PROGRAM NAME	
97. EMPLOYER'S NAME OR PROGRAM NAME		98. EMPLOYER'S NAME OR PROGRAM NAME	
99. EMPLOYER'S NAME OR PROGRAM NAME		100. EMPLOYER'S NAME OR PROGRAM NAME	

UCC Instruction Manual available at: www.ucc.org

APPROVED CMB-0333-0289 FORM CMS-1500 (08/03)

Environmental Assessments

Procedure Code	Services	Unit of Service	*Rate per Unit
W1725	Environmental Assessment	An assessment	The lesser of \$387.68 per unit or the provider's usual and customary charge.

Following are specific instructions for billing for Environmental Assessment services under the Waiver for Older Adults.

- Providers must be approved to provide Environmental Assessment services under the Medicaid Waiver for Older Adults
- A "unit of service" is a completed Environmental Assessment on a form approved by the Program
- This service and provider must be listed in the participant's approved Plan of Care.
- The services must be rendered by a licensed occupational therapist.
- Services may be provided to waiver participants residing either at home or in an assisted living facility
- Medicaid will pay the provider the lesser of: \$395.59 per unit of service or the provider's usual and customary charges, reduced for any payments by Medicare or another insurer.
- Other third party insurances should be billed prior to billing the Medicaid Waiver.
- See COMAR 10.09.54.19 for additional information on reimbursement for this service.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an original signature - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Environmental Assessment

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 05/05

1. MEDICAR
☐ MEDICAID
☐ PRIVATE
☐ OTHER (Specify)

2. PATIENT'S NAME (Last, First, Middle Initial)
Doe, John

3. PATIENT'S BIRTH DATE
01/22/29

4. INSURED'S NAME (Last, First, Middle Initial)
Doe, John

5. PATIENT'S ADDRESS (Street, City, State, ZIP)
100 Center Street
Baltimore, MD 21200

6. PATIENT'S RELATIONSHIP TO INSURED
Self

7. INSURED'S ADDRESS (Street, City, State, ZIP)
100 Center Street
Baltimore, MD 21200

8. OTHER INSURED'S NAME (Last, First, Middle Initial)
Doe, Jane

9. EMPLOYMENT (Employer, Position)
Employed

10. PATIENT'S CONDITION (Affected By)
No

11. INSURED'S POLICY GROUP OR IDENTIFICATION NUMBER
K

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
[Signature]

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
[Signature]

14. DATE OF SERVICE
01/23/07

15. DATE OF REFERENCE PROVIDER OR OTHER SOURCE
01/23/07

16. RECEIVED FOR LOCAL USE

17. DISPOSITION OR NATURE OF CLAIM (Check one)
1. [] 2. [] 3. [] 4. []

18. FEDERAL TAX ID NUMBER
SEN EIN

19. PATIENT'S ACCOUNT NO.
W1725

20. TOTAL CHARGE
\$393

21. AMOUNT PAID
65

22. BALANCE DUE
328

23. SIGNATURE OF PHYSICIAN OR SUPPLIER
[Signature]

24. SERVICE FACILITY LOCATION INFORMATION
500 Mount Street
Baltimore, MD

25. AUTHORIZED REPRESENTATIVE
EYZ Agency
500 Mount Street
Baltimore, MD

26. ORIGINAL INFORMATION
[]

27. COPIES OF THIS FORM
1

28. DATE
01/23/07

29. TIME
10:00

30. PHONE NUMBER
410-333-3333

31. FAX NUMBER
410-333-3333

32. E-MAIL ADDRESS
[]

33. WEBSITE
[]

34. OTHER INFORMATION
[]

35. OTHER INFORMATION
[]

36. OTHER INFORMATION
[]

37. OTHER INFORMATION
[]

38. OTHER INFORMATION
[]

39. OTHER INFORMATION
[]

40. OTHER INFORMATION
[]

41. OTHER INFORMATION
[]

42. OTHER INFORMATION
[]

43. OTHER INFORMATION
[]

44. OTHER INFORMATION
[]

45. OTHER INFORMATION
[]

46. OTHER INFORMATION
[]

47. OTHER INFORMATION
[]

48. OTHER INFORMATION
[]

49. OTHER INFORMATION
[]

50. OTHER INFORMATION
[]

51. OTHER INFORMATION
[]

52. OTHER INFORMATION
[]

53. OTHER INFORMATION
[]

54. OTHER INFORMATION
[]

55. OTHER INFORMATION
[]

56. OTHER INFORMATION
[]

57. OTHER INFORMATION
[]

58. OTHER INFORMATION
[]

59. OTHER INFORMATION
[]

60. OTHER INFORMATION
[]

61. OTHER INFORMATION
[]

62. OTHER INFORMATION
[]

63. OTHER INFORMATION
[]

64. OTHER INFORMATION
[]

65. OTHER INFORMATION
[]

66. OTHER INFORMATION
[]

67. OTHER INFORMATION
[]

68. OTHER INFORMATION
[]

69. OTHER INFORMATION
[]

70. OTHER INFORMATION
[]

71. OTHER INFORMATION
[]

72. OTHER INFORMATION
[]

73. OTHER INFORMATION
[]

74. OTHER INFORMATION
[]

75. OTHER INFORMATION
[]

76. OTHER INFORMATION
[]

77. OTHER INFORMATION
[]

78. OTHER INFORMATION
[]

79. OTHER INFORMATION
[]

80. OTHER INFORMATION
[]

81. OTHER INFORMATION
[]

82. OTHER INFORMATION
[]

83. OTHER INFORMATION
[]

84. OTHER INFORMATION
[]

85. OTHER INFORMATION
[]

86. OTHER INFORMATION
[]

87. OTHER INFORMATION
[]

88. OTHER INFORMATION
[]

89. OTHER INFORMATION
[]

90. OTHER INFORMATION
[]

91. OTHER INFORMATION
[]

92. OTHER INFORMATION
[]

93. OTHER INFORMATION
[]

94. OTHER INFORMATION
[]

95. OTHER INFORMATION
[]

96. OTHER INFORMATION
[]

97. OTHER INFORMATION
[]

98. OTHER INFORMATION
[]

99. OTHER INFORMATION
[]

100. OTHER INFORMATION
[]

Family or Consumer Training

Procedure Code	Services	Unit of Service	*Rate per Unit
W0208	Family or Consumer Training	One Hour	\$ 60.93 per hour

Following are specific instructions for billing Family or Consumer Training services under the Waiver for Older Adults:

- Providers must be approved to provide Family or Consumer Training services under the Medicaid Waiver for Older Adults
- A "unit of service" for family or consumer training is an hour of service rendered:
 1. by one of the following: licensed occupational therapist, physical therapist, registered nurse, or social worker,
 2. one-on-one during a home or office-visit with the waiver participant and/or family member.
- The topics covered by the training and counseling services must be specified in the waiver participant's approved Plan of Care and must be targeted to the individualized needs of the participant or family member receiving the training, as related to the participant's needs.
- The training may not be rendered on a group basis or in a classroom setting.
- The provider may only bill for the length of the visit. Related activities performed before or after the visit (such as planning, preparing, setting up the training, and/or following up after the training) are not covered.
- See COMAR 10.09.54.26 for additional information on reimbursement for this service.
- Medicaid will pay the provider the lesser of: \$62.17 per unit of service or the provider's usual and customary charge.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Family or Consumer Training

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/>		2. INSURED'S ID NUMBER (For Page 1 & 2)	
3. PATIENT'S NAME (Last, First, Middle Initial) Doe, John		4. INSURED'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (No. & Street) 100 Center Street		6. INSURED'S ADDRESS (No. & Street)	
7. CITY Baltimore, MD		8. STATE	
9. ZIP CODE 21200		10. TELEPHONE (Include Area Code) (410) 333-3333	
11. OTHER INSURED NAME (Last, First, Middle Initial)		12. INSURED'S POLICY GROUP OR PROGRAM NAME	
13. OTHER INSURED'S DATE OF BIRTH		14. INSURED'S DATE OF BIRTH	
15. OTHER INSURED'S NAME OR SCHOOL NAME		16. EMPLOYER'S NAME OR SCHOOL NAME	
17. INSURANCE PLAN NAME OR PROGRAM NAME		18. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
21. DATE		22. DATE	
23. DATE OF SERVICE		24. DATE OF SERVICE	
25. NAME OF REFERRING PROVIDER OR OTHER SOURCE		26. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
27. RESERVED FOR LOCAL USE		28. RESERVED FOR LOCAL USE	
29. DISPOSABLE SIGNATURE OF ALLERIES ON REFENT (Check box 1, 2, 3 or 4 in box 29 by line)		30. DISPOSABLE SIGNATURE OF ALLERIES ON REFENT (Check box 1, 2, 3 or 4 in box 29 by line)	
31. DATE(S) OF SERVICE		32. DATE(S) OF SERVICE	
33. PROCEDURE, SERVICE, OR SUPPLY		34. PROCEDURE, SERVICE, OR SUPPLY	
35. CHARGE		36. CHARGE	
37. TOTAL CHARGE		38. TOTAL CHARGE	
39. AMOUNT PAID		40. AMOUNT PAID	
41. BALANCE DUE		42. BALANCE DUE	
43. SIGNATURE OF PROVIDER OR SUPPLIER		44. SIGNATURE OF PROVIDER OR SUPPLIER	
45. SERVICE FACILITY LOCATION INFORMATION		46. SERVICE FACILITY LOCATION INFORMATION	
47. ORIGINAL DATE		48. ORIGINAL DATE	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0333-0399 FORM CMB-1500 (08/03)

Home-Delivered Meals

Procedure Code	Services	Unit of Service	*Rate per Unit
W0211	Home Delivered Meals	One Meal	\$ 5.54 per meal

Following are specific instructions for billing Home-Delivered Meals under the Waiver for Older Adults.

- Providers must be approved to provide Home-Delivered Meals services under the Medicaid Waiver for Older Adults.
- A "unit of service" for Home-Delivered Meals is one meal delivered to the participant's home (includes the cost of food, food preparation, and delivery)
- This service, provider and the number of "units" (meals) must be listed in the participant's approved Plan of Care.
- Medicaid will pay a maximum of two units of service per day for a waiver participant.
- Services may only be provided to waiver participants residing at home.
- Medicaid will pay the provider the lesser of: \$5.65 per meal or the provider's usual and customary charge to the general public for each delivered meal.
- Medicaid payment must be considered as payment in full for a home-delivered meal and may not supplement or be supplemented by payment from other sources, such as the Older Americans Act.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Note: Medicaid coverage, combined with Older Americans Act coverage through the local Area Agency on Aging, may not constitute the individual's full daily nutritional regimen of three meals.

Sample Claim for Home Delivered Meals

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 2005

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> OTHER <input type="checkbox"/>		2. INSURED'S I.D. NUMBER (For Private Plans)	
3. PATIENT'S BIRTH DATE 01/22/29		4. INSURED'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (City, State, Zip) Baltimore, MD 21209		6. INSURED'S ADDRESS (City, State, Zip)	
7. PATIENT'S PHONE (Area Code) (410) 333-3333		8. INSURED'S PHONE (Area Code) () ()	
9. OTHER INSURED'S BIRTH DATE (MM/DD/YY)		10. INSURED'S POLICY GROUP OR ACCOUNT NUMBER	
10. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY)		11. INSURED'S DATE OF BIRTH (MM/DD/YY)	
11. OTHER INSURED'S NAME OR SCHOOL NAME		12. EMPLOYER'S NAME OR SCHOOL NAME	
12. INSURANCE PLAN NAME OR PROGRAM NAME		13. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
13. PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE		14. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
14. SIGNED DATE		15. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
15. DATE OF CURRENT CLAIM (MM/DD/YY)		16. DATE PATIENT WAS INJURED OR BECAME DISABLED (MM/DD/YY)	
16. NAME OF REPERFUSION PROVIDER OR OTHER COURSE		17. DATE OF REPERFUSION (MM/DD/YY)	
17. RESERVED FOR LOCAL USE		18. OUTSIDE LAB?	
18. OUTSIDE LAB?		19. OUTSIDE LAB?	
19. OUTSIDE LAB?		20. OUTSIDE LAB?	
20. OUTSIDE LAB?		21. OUTSIDE LAB?	
21. OUTSIDE LAB?		22. OUTSIDE LAB?	
22. OUTSIDE LAB?		23. OUTSIDE LAB?	
23. OUTSIDE LAB?		24. OUTSIDE LAB?	
24. OUTSIDE LAB?		25. OUTSIDE LAB?	
25. OUTSIDE LAB?		26. OUTSIDE LAB?	
26. OUTSIDE LAB?		27. OUTSIDE LAB?	
27. OUTSIDE LAB?		28. OUTSIDE LAB?	
28. OUTSIDE LAB?		29. OUTSIDE LAB?	
29. OUTSIDE LAB?		30. OUTSIDE LAB?	
30. OUTSIDE LAB?		31. OUTSIDE LAB?	
31. OUTSIDE LAB?		32. OUTSIDE LAB?	
32. OUTSIDE LAB?		33. OUTSIDE LAB?	
33. OUTSIDE LAB?		34. OUTSIDE LAB?	
34. OUTSIDE LAB?		35. OUTSIDE LAB?	
35. OUTSIDE LAB?		36. OUTSIDE LAB?	
36. OUTSIDE LAB?		37. OUTSIDE LAB?	
37. OUTSIDE LAB?		38. OUTSIDE LAB?	
38. OUTSIDE LAB?		39. OUTSIDE LAB?	
39. OUTSIDE LAB?		40. OUTSIDE LAB?	
40. OUTSIDE LAB?		41. OUTSIDE LAB?	
41. OUTSIDE LAB?		42. OUTSIDE LAB?	
42. OUTSIDE LAB?		43. OUTSIDE LAB?	
43. OUTSIDE LAB?		44. OUTSIDE LAB?	
44. OUTSIDE LAB?		45. OUTSIDE LAB?	
45. OUTSIDE LAB?		46. OUTSIDE LAB?	
46. OUTSIDE LAB?		47. OUTSIDE LAB?	
47. OUTSIDE LAB?		48. OUTSIDE LAB?	
48. OUTSIDE LAB?		49. OUTSIDE LAB?	
49. OUTSIDE LAB?		50. OUTSIDE LAB?	
50. OUTSIDE LAB?		51. OUTSIDE LAB?	
51. OUTSIDE LAB?		52. OUTSIDE LAB?	
52. OUTSIDE LAB?		53. OUTSIDE LAB?	
53. OUTSIDE LAB?		54. OUTSIDE LAB?	
54. OUTSIDE LAB?		55. OUTSIDE LAB?	
55. OUTSIDE LAB?		56. OUTSIDE LAB?	
56. OUTSIDE LAB?		57. OUTSIDE LAB?	
57. OUTSIDE LAB?		58. OUTSIDE LAB?	
58. OUTSIDE LAB?		59. OUTSIDE LAB?	
59. OUTSIDE LAB?		60. OUTSIDE LAB?	
60. OUTSIDE LAB?		61. OUTSIDE LAB?	
61. OUTSIDE LAB?		62. OUTSIDE LAB?	
62. OUTSIDE LAB?		63. OUTSIDE LAB?	
63. OUTSIDE LAB?		64. OUTSIDE LAB?	
64. OUTSIDE LAB?		65. OUTSIDE LAB?	
65. OUTSIDE LAB?		66. OUTSIDE LAB?	
66. OUTSIDE LAB?		67. OUTSIDE LAB?	
67. OUTSIDE LAB?		68. OUTSIDE LAB?	
68. OUTSIDE LAB?		69. OUTSIDE LAB?	
69. OUTSIDE LAB?		70. OUTSIDE LAB?	
70. OUTSIDE LAB?		71. OUTSIDE LAB?	
71. OUTSIDE LAB?		72. OUTSIDE LAB?	
72. OUTSIDE LAB?		73. OUTSIDE LAB?	
73. OUTSIDE LAB?		74. OUTSIDE LAB?	
74. OUTSIDE LAB?		75. OUTSIDE LAB?	
75. OUTSIDE LAB?		76. OUTSIDE LAB?	
76. OUTSIDE LAB?		77. OUTSIDE LAB?	
77. OUTSIDE LAB?		78. OUTSIDE LAB?	
78. OUTSIDE LAB?		79. OUTSIDE LAB?	
79. OUTSIDE LAB?		80. OUTSIDE LAB?	
80. OUTSIDE LAB?		81. OUTSIDE LAB?	
81. OUTSIDE LAB?		82. OUTSIDE LAB?	
82. OUTSIDE LAB?		83. OUTSIDE LAB?	
83. OUTSIDE LAB?		84. OUTSIDE LAB?	
84. OUTSIDE LAB?		85. OUTSIDE LAB?	
85. OUTSIDE LAB?		86. OUTSIDE LAB?	
86. OUTSIDE LAB?		87. OUTSIDE LAB?	
87. OUTSIDE LAB?		88. OUTSIDE LAB?	
88. OUTSIDE LAB?		89. OUTSIDE LAB?	
89. OUTSIDE LAB?		90. OUTSIDE LAB?	
90. OUTSIDE LAB?		91. OUTSIDE LAB?	
91. OUTSIDE LAB?		92. OUTSIDE LAB?	
92. OUTSIDE LAB?		93. OUTSIDE LAB?	
93. OUTSIDE LAB?		94. OUTSIDE LAB?	
94. OUTSIDE LAB?		95. OUTSIDE LAB?	
95. OUTSIDE LAB?		96. OUTSIDE LAB?	
96. OUTSIDE LAB?		97. OUTSIDE LAB?	
97. OUTSIDE LAB?		98. OUTSIDE LAB?	
98. OUTSIDE LAB?		99. OUTSIDE LAB?	
99. OUTSIDE LAB?		100. OUTSIDE LAB?	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMS-0333-0599 FORM CMS-1500 (08/03)

Personal Care Services

Note:

Waiver Personal Care Services will not be paid for the same date of service as Medicaid State Plan Personal Care (MAPC) services.

Personal care services cannot be billed for any days that the participant was inpatient at a hospital, nursing facility or other medical institution.

Self-Employed Personal Care Aide – Non-Delegated

Procedure Code	Services	Unit of Service	*Rate per Unit
W0200	Self-Employed PC Aide: non-delegated services (no medication administration)	1 hour	\$9.97 per hour

Following are specific instructions for billing for Self-Employed Personal Care – non-delegated services (without medication administration) under the Waiver for Older Adults:

- A provider must be enrolled to provide non-delegated services under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted).
- These services can only be provided to enrolled Waiver participants residing at home.
- This service, provider and units of service per day and/or week must be listed in the participant's approved Plan of Care.
- Self-Employed Personal Care Aides providing non-delegated services (without medication administration), must possess the following minimum qualifications:
 - A valid Medicaid Waiver provider number
 - Current First Aid and CPR (it is your responsibility to maintain these certifications)
 - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a nurse monitor assigned to the participant.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Self-Employed Personal Care Aide - Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0201	Self-Employed PC Aide – <u>delegated services (with medication administration)</u>	1 hour	\$13.00 per hour

Following are specific instructions for billing for self-employed personal care –delegated services (with medication administration) under the Waiver for Older Adults

- A provider must be enrolled to provide delegated services under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted)

- These services can only be provided to approved Waiver participants residing at home
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- Self-employed personal care aides providing delegated (with medication administration) services must possess the following qualifications:
 - A valid Medicaid Waiver provider number
 - Current First Aid and CPR (it is your responsibility to maintain these certifications)
 - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a nurse monitor assigned to the participant
 - One of the following combinations of credentials:
 - Certified Nursing Assistant (CNA) and Medication Technician (MT) Certification, or
 - Geriatric Nursing Assistant (GNA) and Medication Technician (MT) Certification, or
 - Certified Medication Technician (CMA) You must have a CNA before receiving a CMA)

Note: Certifications **must** be **current** and **verifiable** from the Maryland Board of Nursing.

- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Non-Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0202	Agency-Employed PC Aide - <u>non-delegated services (no medication administration)</u>	1 hour	\$12.75

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing non-delegated services (without medication administration) under the Waiver for Older Adults:

- The Agency must be enrolled to provide personal care services non-delegated services (no medication administration) under the Medicaid Waiver for Older Adults.
- A "unit of service" is one hour (no partial hour increments are accepted).
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- These services can only be provided to approved Waiver participants residing at home
- Agency employed personal care aides providing non-delegated services (without medication administration), must possess the following minimum qualifications:
 - Current First Aid and CPR (it is your responsibility to maintain these certifications)
 - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a licensed registered nurse or nurse monitor as stated before?
 - A criminal background check submitted by Criminal Justice Information Services (CJIS) in the Agency's name, verifying that the employee has a clear record that contains no probation before judgment(s) or criminal conviction (The agency responsibility is to maintain current and up-to-date records on each employee).
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Delegated Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0203	Agency-Employed PC aide - <u>delegated services (with medication administration)</u>	1 hour	\$16.61

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing delegated services (with medication administration) under the Waiver for Older Adults:

- Personal Care Agencies must be enrolled and approved to provide delegated services (with medication administration) under the Medicaid Waiver for Older Adults
- A "unit of service" is one hour (no partial hour increments are accepted)
- Agencies must be approved to provide Agency Personal Care Services - delegated (with medication administration) under the Medicaid Waiver for Older Adults.
- This service, the provider and the units of service per day and/or week must be listed in the participant's approved Plan of Care.
- These services can only be provided to approved Waiver participants residing at home
- Agency employed personal care aides providing delegated services (with medication administration) must possess the following qualifications:
 - Current First Aid and CPR
 - Ability to understand the instructions in the participant's plan of care and perform required duties satisfactorily in the presence of a licensed registered nurse
 - A criminal background check submitted by Criminal Justice Information Services (CJIS) in the hiring Agency's name, verifying that the employee has a clear record that contains no probation before judgment(s) or criminal conviction (The agency is responsible to maintain current and up-to-date records on each employee).
 - One of the following combinations of credentials:
 - Certified Nursing Assistant (CNA and Medication Technician (MT) Certification, or
 - Geriatric Nursing Assistant (GNA) and Medication Technician (MT) Certification, or
 - Certified Medicine Aide (CMA)
 - Note: These certifications **must be current and verifiable** from the Maryland Board of Nursing. (The agency responsibility is to maintain current and up-to-date records on each employee and to verify that certifications are current and remain current).
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Agency Nurse Monitoring Services

Procedure Code	Services	Unit of Service	*Rate per Unit
W0204	Personal Care Agency Nurse Monitoring	1 hour	\$60.93

Following are specific instructions for billing Agency-Employed Personal Care-Aides providing delegated services

(with medication administration) under the Waiver for Older Adults:

- Providers must be approved to provide Agency Nurse Monitoring Services under the Medicaid Waiver for Older Adults.

- A "unit of service" for Nurse Monitor is one (1) hour (no partial hour increments are accepted).
- This service, the provider and the units of service per month must be listed in the participant's approved Plan of Care.
- This services can only be provided to approved Waiver participants residing at home
- Agency Employed Nurse Monitors must possess a RN license, **current** and **verifiable** from the Maryland Board of Nursing. (The agency responsibility is to maintain current and up-to-date records on each employee and to verify that certifications are current and remain current).
- Nurse Monitoring services may include, but are not limited to:
 - Assessing the participant's medical condition.
 - Developing a waiver participant's specific service plan (Caregiver Service Plan)
 - Evaluating a prospective personal care aide's ability to understand and carry out the participant specific plan-of-care (Caregiver Assessment).
 - Providing instruction and training to a personal care aide in the performance of specific services listed in the participant's specific service plan.
 - Supervising the care given to a waiver participant by a personal care aide
- See COMAR 10.09.54.06 & .22 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care
- Requests for reimbursement must include a copy of a DHMH 4658D –Nurse Monitor Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an original signature - NO FAXED COPIES ARE ACCEPTED

**Sample Claim for Self-Employed Personal Care Aide: Non-Delegated:
8 Hours Per Day, Seven Days Per Week**

1500										HEALTH INSURANCE CLAIM FORM									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)										FICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TAXING CREDIT <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FICA <input type="checkbox"/> OTHER <input type="checkbox"/> COBRA <input type="checkbox"/>										11. INSURED'S I.D. NUMBER (For Private Plan)									
2. PATIENT'S NAME (Last, First, Middle Initial) Doe, John										4. INSURED'S NAME (Last, First, Middle Initial)									
3. PATIENT'S ADDRESS (No. & Street) 100 Center Street										7. INSURED'S ADDRESS (No. & Street)									
CITY Baltimore, STATE MD										CITY STATE									
ZIP CODE 21200 TELEPHONE (410) 333-3333										2.P. CODE TELEPHONE (Include Area Code)									
8. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										9. PATIENT'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other <input type="checkbox"/>									
10. PATIENT'S EMPLOYMENT STATUS Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/>										11. INSURED'S EMPLOYMENT STATUS Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/>									
12. PATIENT'S DATE OF BIRTH MM DD YY										13. INSURED'S DATE OF BIRTH MM DD YY									
14. PATIENT'S SOCIAL SECURITY NUMBER										15. INSURED'S SOCIAL SECURITY NUMBER									
16. PATIENT'S SIGNATURE										17. INSURED'S SIGNATURE									
18. PATIENT'S DATE OF SIGNATURE										19. INSURED'S DATE OF SIGNATURE									
20. PATIENT'S ADDRESS (No. & Street)										21. INSURED'S ADDRESS (No. & Street)									
22. PATIENT'S CITY										23. INSURED'S CITY									
24. PATIENT'S STATE										25. INSURED'S STATE									
26. PATIENT'S ZIP CODE										27. INSURED'S ZIP CODE									
28. PATIENT'S TELEPHONE										29. INSURED'S TELEPHONE									
30. PATIENT'S FAX										31. INSURED'S FAX									
32. PATIENT'S SIGNATURE										33. INSURED'S SIGNATURE									
34. PATIENT'S DATE OF SIGNATURE										35. INSURED'S DATE OF SIGNATURE									
36. PATIENT'S ADDRESS (No. & Street)										37. INSURED'S ADDRESS (No. & Street)									
38. PATIENT'S CITY										39. INSURED'S CITY									
40. PATIENT'S STATE										41. INSURED'S STATE									
42. PATIENT'S ZIP CODE										43. INSURED'S ZIP CODE									
44. PATIENT'S TELEPHONE										45. INSURED'S TELEPHONE									
46. PATIENT'S FAX										47. INSURED'S FAX									
48. PATIENT'S SIGNATURE										49. INSURED'S SIGNATURE									
50. PATIENT'S DATE OF SIGNATURE										51. INSURED'S DATE OF SIGNATURE									
52. PATIENT'S ADDRESS (No. & Street)										53. INSURED'S ADDRESS (No. & Street)									
54. PATIENT'S CITY										55. INSURED'S CITY									
56. PATIENT'S STATE										57. INSURED'S STATE									
58. PATIENT'S ZIP CODE										59. INSURED'S ZIP CODE									
60. PATIENT'S TELEPHONE										61. INSURED'S TELEPHONE									
62. PATIENT'S FAX										63. INSURED'S FAX									
64. PATIENT'S SIGNATURE										65. INSURED'S SIGNATURE									
66. PATIENT'S DATE OF SIGNATURE										67. INSURED'S DATE OF SIGNATURE									
68. PATIENT'S ADDRESS (No. & Street)										69. INSURED'S ADDRESS (No. & Street)									
70. PATIENT'S CITY										71. INSURED'S CITY									
72. PATIENT'S STATE										73. INSURED'S STATE									
74. PATIENT'S ZIP CODE										75. INSURED'S ZIP CODE									
76. PATIENT'S TELEPHONE										77. INSURED'S TELEPHONE									
78. PATIENT'S FAX										79. INSURED'S FAX									
80. PATIENT'S SIGNATURE										81. INSURED'S SIGNATURE									
82. PATIENT'S DATE OF SIGNATURE										83. INSURED'S DATE OF SIGNATURE									
84. PATIENT'S ADDRESS (No. & Street)										85. INSURED'S ADDRESS (No. & Street)									
86. PATIENT'S CITY										87. INSURED'S CITY									
88. PATIENT'S STATE										89. INSURED'S STATE									
90. PATIENT'S ZIP CODE										91. INSURED'S ZIP CODE									
92. PATIENT'S TELEPHONE										93. INSURED'S TELEPHONE									
94. PATIENT'S FAX										95. INSURED'S FAX									
96. PATIENT'S SIGNATURE										97. INSURED'S SIGNATURE									
98. PATIENT'S DATE OF SIGNATURE										99. INSURED'S DATE OF SIGNATURE									
100. PATIENT'S ADDRESS (No. & Street)										101. INSURED'S ADDRESS (No. & Street)									
102. PATIENT'S CITY										103. INSURED'S CITY									
104. PATIENT'S STATE										105. INSURED'S STATE									
106. PATIENT'S ZIP CODE										107. INSURED'S ZIP CODE									
108. PATIENT'S TELEPHONE										109. INSURED'S TELEPHONE									
110. PATIENT'S FAX										111. INSURED'S FAX									
112. PATIENT'S SIGNATURE										113. INSURED'S SIGNATURE									
114. PATIENT'S DATE OF SIGNATURE										115. INSURED'S DATE OF SIGNATURE									
116. PATIENT'S ADDRESS (No. & Street)										117. INSURED'S ADDRESS (No. & Street)									
118. PATIENT'S CITY										119. INSURED'S CITY									
120. PATIENT'S STATE										121. INSURED'S STATE									
122. PATIENT'S ZIP CODE										123. INSURED'S ZIP CODE									
124. PATIENT'S TELEPHONE										125. INSURED'S TELEPHONE									
126. PATIENT'S FAX										127. INSURED'S FAX									
128. PATIENT'S SIGNATURE										129. INSURED'S SIGNATURE									
130. PATIENT'S DATE OF SIGNATURE										131. INSURED'S DATE OF SIGNATURE									
132. PATIENT'S ADDRESS (No. & Street)										133. INSURED'S ADDRESS (No. & Street)									
134. PATIENT'S CITY										135. INSURED'S CITY									
136. PATIENT'S STATE										137. INSURED'S STATE									
138. PATIENT'S ZIP CODE										139. INSURED'S ZIP CODE									
140. PATIENT'S TELEPHONE										141. INSURED'S TELEPHONE									
142. PATIENT'S FAX										143. INSURED'S FAX									
144. PATIENT'S SIGNATURE										145. INSURED'S SIGNATURE									
146. PATIENT'S DATE OF SIGNATURE										147. INSURED'S DATE OF SIGNATURE									
148. PATIENT'S ADDRESS (No. & Street)										149. INSURED'S ADDRESS (No. & Street)									
150. PATIENT'S CITY										151. INSURED'S CITY									
152. PATIENT'S STATE										153. INSURED'S STATE									
154. PATIENT'S ZIP CODE										155. INSURED'S ZIP CODE									
156. PATIENT'S TELEPHONE										157. INSURED'S TELEPHONE									
158. PATIENT'S FAX										159. INSURED'S FAX									
160. PATIENT'S SIGNATURE										161. INSURED'S SIGNATURE									
162. PATIENT'S DATE OF SIGNATURE										163. INSURED'S DATE OF SIGNATURE									
164. PATIENT'S ADDRESS (No. & Street)										165. INSURED'S ADDRESS (No. & Street)									
166. PATIENT'S CITY										167. INSURED'S CITY									
168. PATIENT'S STATE										169. INSURED'S STATE									
170. PATIENT'S ZIP CODE										171. INSURED'S ZIP CODE									
172. PATIENT'S TELEPHONE										173. INSURED'S TELEPHONE									
174. PATIENT'S FAX										175. INSURED'S FAX									
176. PATIENT'S SIGNATURE										177. INSURED'S SIGNATURE									
178. PATIENT'S DATE OF SIGNATURE										179. INSURED'S DATE OF SIGNATURE									
180. PATIENT'S ADDRESS (No. & Street)										181. INSURED'S ADDRESS (No. & Street)									
182. PATIENT'S CITY										183. INSURED'S CITY									
184. PATIENT'S STATE										185. INSURED'S STATE									
186. PATIENT'S ZIP CODE										187. INSURED'S ZIP CODE									
188. PATIENT'S TELEPHONE										189. INSURED'S TELEPHONE									
190. PATIENT'S FAX										191. INSURED'S FAX									
192. PATIENT'S SIGNATURE										193. INSURED'S SIGNATURE									
194. PATIENT'S DATE OF SIGNATURE										195. INSURED'S DATE OF SIGNATURE									
196. PATIENT'S ADDRESS (No. & Street)										197. INSURED'S ADDRESS (No. & Street)									
198. PATIENT'S CITY										199. INSURED'S CITY									
200. PATIENT'S STATE										201. INSURED'S STATE									
202. PATIENT'S ZIP CODE										203. INSURED'S ZIP CODE									
204. PATIENT'S TELEPHONE										205. INSURED'S TELEPHONE									
206. PATIENT'S FAX										207. INSURED'S FAX									
208. PATIENT'S SIGNATURE										209. INSURED'S SIGNATURE									
210. PATIENT'S DATE OF SIGNATURE										211. INSURED'S DATE OF SIGNATURE									
212. PATIENT'S ADDRESS (No. & Street)										213. INSURED'S ADDRESS (No. & Street)									
214. PATIENT'S CITY										215. INSURED'S CITY									
216. PATIENT'S STATE										217. INSURED'S STATE									
218. PATIENT'S ZIP CODE										219. INSURED'S ZIP CODE									
220. PATIENT'S TELEPHONE										221. INSURED'S TELEPHONE									
222. PATIENT'S FAX										223. INSURED'S FAX									
224. PATIENT'S SIGNATURE										225. INSURED'S SIGNATURE									
226. PATIENT'S DATE OF SIGNATURE										227. INSURED'S DATE OF SIGNATURE									
228. PATIENT'S ADDRESS (No. & Street)										229. INSURED'S ADDRESS (No. & Street)									
230. PATIENT'S CITY										231. INSURED'S CITY									
232. PATIENT'S STATE										233. INSURED'S STATE									
234. PATIENT'S ZIP CODE										235. INSURED'S ZIP CODE									
236. PATIENT'S TELEPHONE										237. INSURED'S TELEPHONE									
238. PATIENT'S FAX										239. INSURED'S FAX									
240. PATIENT'S SIGNATURE										241. INSURED'S SIGNATURE									
242. PATIENT'S DATE OF SIGNATURE										243. INSURED'S DATE OF SIGNATURE									
244. PATIENT'S ADDRESS (No. & Street)										245. INSURED'S ADDRESS (No. & Street)									
246. PATIENT'S CITY										247. INSURED'S CITY									
248. PATIENT'S STATE										249. INSURED'S STATE									
250. PATIENT'S ZIP CODE										251. INSURED'S ZIP CODE									
252. PATIENT'S TELEPHONE										253. INSURED'S TELEPHONE									
254. PATIENT'S FAX										255. INSURED'S FAX									
256. PATIENT'S SIGNATURE										257. INSURED'S SIGNATURE									
258. PATIENT'S DATE OF SIGNATURE										259. INSURED'S DATE OF SIGNATURE									
260. PATIENT'S ADDRESS (No. & Street)										261. INSURED'S ADDRESS (No. & Street)									
262. PATIENT'S CITY										263. INSURED'S CITY									
264. PATIENT'S STATE										265. INSURED'S STATE									
266. PATIENT'S ZIP CODE										267. INSURED'S ZIP CODE									
268. PATIENT'S TELEPHONE										269. INSURED'S TELEPHONE									
270. PATIENT'S FAX										271. INSURED'S FAX									
272. PATIENT'S SIGNATURE										273. INSURED'S SIGNATURE									
274. PATIENT'S DATE OF SIGNATURE										275. INSURED'S DATE OF SIGNATURE									
276. PATIENT'S ADDRESS (No. & Street)										277. INSURED'S ADDRESS (No. & Street)									
278. PATIENT'S CITY										279. INSURED'S CITY									
280. PATIENT'S STATE										281. INSURED'S STATE									
282. PATIENT'S ZIP CODE										283. INSURED'S ZIP CODE									
284. PATIENT'S TELEPHONE										285. INSURED'S TELEPHONE									
286. PATIENT'S FAX										287. INSURED'S FAX									
288. PATIENT'S SIGNATURE										289. INSURED'S SIGNATURE									
290. PATIENT'S DATE OF SIGNATURE										291. INSURED'S DATE OF SIGNATURE									
292. PATIENT'S ADDRESS (No. & Street)										293. INSURED'S ADDRESS (No. & Street)									
294. PATIENT'S CITY										295. INSURED'S CITY									
296. PATIENT'S STATE										297. INSURED'S STATE									
298. PATIENT'S ZIP CODE										299. INSURED'S ZIP CODE									
300. PATIENT'S TELEPHONE										301. INSURED'S TELEPHONE									
302. PATIENT'S FAX										303. INSURED'S FAX									
304. PATIENT'S SIGNATURE										305. INSURED'S SIGNATURE									
306. PATIENT'S DATE OF SIGNATURE										307. INSURED'S DATE OF SIGNATURE									
308. PATIENT'S ADDRESS (No. & Street)										309. INSURED'S ADDRESS (No. & Street)									
310. PATIENT'S CITY										311. INSURED'S CITY									
312. PATIENT'S STATE										313. INSURED'S STATE									
314. PATIENT'S ZIP CODE										315. INSURED'S ZIP CODE									
316. PATIENT'S TELEPHONE										317. INSURED'S TELEPHONE									
318. PATIENT'S FAX										319. INSURED'S FAX									
320. PATIENT'S SIGNATURE										321. INSURED'S SIGNATURE									
322. PATIENT'S DATE OF SIGNATURE										323. INSURED'S DATE OF SIGNATURE									
324. PATIENT'S ADDRESS (No. & Street)										325. INSURED'S ADDRESS (No. & Street)									
326. PATIENT'S CITY										327. INSURED'S CITY									
328. PATIENT'S STATE										329. INSURED'S STATE									
330. PATIENT'S ZIP CODE										331. INSURED'S ZIP CODE									
332. PATIENT'S TELEPHONE										333. INSURED'S TELEPHONE									
334. PATIENT'S FAX										335. INSURED'S FAX									
336. PATIENT'S SIGNATURE										337. INSURED'S SIGNATURE									
338. PATIENT'S DATE OF SIGNATURE										339. INSURED'S DATE OF SIGNATURE									
340. PATIENT'S ADDRESS (No. & Street)										341. INSURED'S ADDRESS (No. & Street)									
342. PATIENT'S CITY										343. INSURED'S CITY									
344. PATIENT'S STATE										345. INSURED'S STATE									
346. PATIENT'S ZIP CODE										347. INSURED'S ZIP CODE									
348. PATIENT'S TELEPHONE										349. INSURED'S TELEPHONE									
350. PATIENT'S FAX										351. INSURED'S FAX									
352. PATIENT'S SIGNATURE										353. INSURED'S SIGNATURE									
354. PATIENT'S DATE OF SIGNATURE										355. INSURED'S DATE OF SIGNATURE									
356. PATIENT'S ADDRESS (No. & Street)										357. INSURED'S ADDRESS (No. & Street)									
358. PATIENT'S CITY										359. INSURED'S CITY									
360. PATIENT'S STATE										361. INSURED'S STATE									
362. PATIENT'S ZIP CODE										363. INSURED'S ZIP CODE									
364. PATIENT'S TELEPHONE										365. INSURED'S TELEPHONE									
366. PATIENT'S FAX										367. INSURED'S FAX									
368. PATIENT'S SIGNATURE										369. INSURED'S SIGNATURE									
370. PATIENT'S DATE OF SIGNATURE										371. INSURED'S DATE OF SIGNATURE									
372. PATIENT'S ADDRESS (No. & Street)										373. INSURED'S ADDRESS (No. & Street)									
374. PATIENT'S CITY										375. INSURED'S CITY									
376. PATIENT'S STATE										377. INSURED'S STATE									
378. PATIENT'S ZIP CODE										379. INSURED'S ZIP CODE									
380. PATIENT'S TELEPHONE										381. INSURED'S TELEPHONE									
382. PATIENT'S FAX										383. INSURED'S FAX									
384. PATIENT'S SIGNATURE										385. INSURED'S SIGNATURE									
386. PATIENT'S DATE OF SIGNATURE										387. INSURED'S DATE OF SIGNATURE									
388. PATIENT'S ADDRESS (No. & Street)										389. INSURED'S ADDRESS (No. & Street)									
390. PATIENT'S CITY										391. INSURED'S CITY									
392. PATIENT'S STATE										393. INSURED'S STATE									
394. PATIENT'S ZIP CODE										395. INSURED'S ZIP CODE									
396. PATIENT'S TELEPHONE										397. INSURED'S TELEPHONE									
398. PATIENT'S FAX										399. INSURED'S FAX									
400. PATIENT'S SIGNATURE										401. INSURED'S SIGNATURE									
402. PATIENT'S DATE OF SIGNATURE										403. INSURED'S DATE OF SIGNATURE									
404. PATIENT'S ADDRESS (No. & Street)										405. INSURED'S ADDRESS (No. & Street)									
406. PATIENT'S CITY										407. INSURED'S CITY									
408. PATIENT'S STATE										409. INSURED'S STATE									
410. PATIENT'S ZIP CODE										411. INSURED'S ZIP CODE									
412. PATIENT'S TELEPHONE										413. INSURED'S TELEPHONE									
414. PATIENT'S FAX										415. INSURED'S FAX									
416. PATIENT'S SIGNATURE										417. INSURED'S SIGNATURE									
418. PATIENT'S DATE OF SIGNATURE										419. INSURED'S DATE OF SIGNATURE									
420. PATIENT'S ADDRESS (No. & Street)										421. INSURED'S ADDRESS (No. & Street)									
422. PATIENT'S CITY										423. INSURED'S CITY									
424. PATIENT'S STATE										425. INSURED'S STATE									
426. PATIENT'S ZIP CODE										427. INSURED'S ZIP CODE									
428. PATIENT'S TELEPHONE										429. INSURED'S TELEPHONE									
430. PATIENT'S FAX										431. INSURED'S FAX									
432. PATIENT'S SIGNATURE										433. INSURED'S SIGNATURE									
434. PATIENT'S DATE OF SIGNATURE										435. INSURED'S DATE OF SIGNATURE									
436. PATIENT'S ADDRESS (No. & Street)										437. INSURED'S ADDRESS (No. & Street)									
438. PATIENT'S CITY										439. INSURED'S CITY									
440. PATIENT'S STATE										441. INSURED'S STATE									
442. PATIENT'S ZIP CODE										443. INSURED'S ZIP CODE									
444. PATIENT'S TELEPHONE										445. INSURED'S TELEPHONE									
446. PATIENT'S FAX										447. INSURED'S FAX									
448. PATIENT'S SIGNATURE										449. INSURED'S SIGNATURE									
450. PATIENT'S DATE OF SIGNATURE										451. INSURED'S DATE OF SIGNATURE									
452. PATIENT'S ADDRESS (No. & Street)										453. INSURED'S ADDRESS (No. & Street)									
454. PATIENT'S CITY										455. INSURED'S CITY									
456. PATIENT'S STATE										457. INSURED'S STATE									
458. PATIENT'S ZIP CODE										459. INSURED'S ZIP CODE									
460. PATIENT'S TELEPHONE										461. INSURED'S TELEPHONE									
462. PATIENT'S FAX										463. INSURED'S FAX									
464. PATIENT'S SIGNATURE										465. INSURED'S SIGNATURE									
466. PATIENT'S DATE OF SIGNATURE										467. INSURED'S DATE OF SIGNATURE									
468. PATIENT'S ADDRESS (No. & Street)										469. INSURED'S ADDRESS (No. & Street)									
470. PATIENT'S CITY										471. INSURED'S CITY									
472. PATIENT'S STATE										473. INSURED'S STATE									
474. PATIENT'S ZIP CODE										475. INSURED'S ZIP CODE									
476. PATIENT'S TELEPHONE										477. INSURED'S TELEPHONE									
478. PATIENT'S FAX										479. INSURED'S FAX									
480. PATIENT'S SIGNATURE										481. INSURED'S SIGNATURE									
482. PATIENT'S DATE OF SIGNATURE										483. INSURED'S DATE OF SIGNATURE									
484. PATIENT'S ADDRESS (No. & Street)										485. INSURED'S ADDRESS (No. & Street)									
486. PATIENT'S CITY										487. INSURED'S CITY									
488. PATIENT'S STATE										489. INSURED'S STATE									
490. PATIENT'S ZIP CODE										491. INSURED'S ZIP CODE									
492. PATIENT'S TELEPHONE										493. INSURED'S TELEPHONE									
494. PATIENT'S FAX										495. INSURED'S FAX									
496. PATIENT'S SIGNATURE										497. INSURED'S SIGNATURE									
498. PATIENT'S DATE OF SIGNATURE										499. INSURED'S DATE OF SIGNATURE									
500. PATIENT'S ADDRESS (No. & Street)										501. INSURED'S ADDRESS (No. & Street)									
502. PATIENT'S CITY										503. INSURED'S CITY									
504. PATIENT'S STATE										505. INSURED'S STATE									
506. PATIENT'S ZIP CODE										507. INSURED'S ZIP CODE									
508. PATIENT'S TELEPHONE										509. INSURED'S TELEPHONE									
510. PATIENT'S FAX										511. INSURED'S FAX									
512. PATIENT'S SIGNATURE										513. INSURED'S SIGNATURE									
514. PATIENT'S DATE OF SIGNATURE										515. INSURED'S DATE OF SIGNATURE									
516. PATIENT'S ADDRESS (No. & Street)										517. INSURED'S ADDRESS (No. & Street)									
518. PATIENT'S CITY																			

Sample Claim for Agency Personal Care- Delegated Nursing Service:
10 hours/day, Seven Days Per Week

WAIVER FOR OLDER ADULT BILLING CLAIM FORM <small>Intend ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging</small>																																	
Participant's Name: John Doe				Participant's Medicaid Number <table border="1" style="width:100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>0</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								0	1	2	3	4	5	6	7	8	9	0											
0	1	2	3	4	5	6	7	8	9	0																							
Address: 401 Center Street City: Baltimore State: Maryland				Participant's Birth Date: <table border="1" style="width:100%; text-align: center;"> <tr> <td>MM</td><td>DD</td><td>YYYY</td> </tr> <tr> <td>1</td><td>1</td><td>1919</td> </tr> </table>		MM	DD	YYYY	1	1	1919	Health Policy Group: <div style="border: 1px solid black; padding: 2px; text-align: center;">H</div>		Participant's Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female																			
MM	DD	YYYY																															
1	1	1919																															
Zip: 21201		Telephone: 410-555-5555																															
Date of Birth			Place of Service			Waiver Procedure Code		Charges		Day/Unit																							
MM	DD	YY	ALF+U	PC+U																													
1	01	01	03	23	12	W0203	155	20	10	1																							
2	01	02	03		12	W0203	155	20	10	2																							
3	01	03	03		12	W0203	155	20	10	3																							
4		04	03		12	W0203	155	20	10	4																							
5	01	05	03		12	W0203	155	20	10	5																							
6	01	06	03		12	W0203	155	20	10	6																							
7	01	07	03		12	W0203	155	20	10	7																							
8	01	08	03		12	W0203	155	20	10	8																							
9	01	09	03		12	W0203	155	20	10	9																							
10	01	10	03		12	W0203	155	20	10	10																							
11	01	11	03		12	W0203	155	20	10	11																							
12	01	12	03		12	W0203	155	20	10	12																							
13	01	13	03		12	W0203	155	20	10	13																							
14	01	14	03		12	W0203	155	20	10	14																							
15	01	15	03		12	W0203	155	20	10	15																							
16	01	16	03		12	W0203	155	20	10	16																							
17	01	17	03		12	W0203	155	20	10	17																							
18	01	18	03		12	W0203	155	20	10	18																							
19	01	19	03		12	W0203	155	20	10	19																							
20	01	20	03		12	W0203	155	20	10	20																							
21	01	21	03		12	W0203	155	20	10	21																							
22	01	22	03		12	W0203	155	20	10	22																							
23										23																							
24										24																							
25										25																							
26										26																							
27										27																							
28										28																							
29										29																							
30										30																							
31										31																							
Your Original Signature: PROVIDER SIGNATURE				PROVIDER/FACILITY NAME AND AGENCY BODMOUNT CHART				\$ 3853.40 TOTAL AMOUNT		TOTAL Units																							
DATE				PROVIDER ADDRESS				PROVIDER #																									
CITY, STATE, ZIP BALTIMORE, MD, 21201				TELEPHONE 410-555-5555				<table border="1" style="width:100%; text-align: center;"> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>0</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>				1	2	3	4	5	6	7	8	9	0												
1	2	3	4	5	6	7	8	9	0																								

(AAA) Claim Processor

MDOA 6-27-97- FINAL

Personal Emergency Response Systems

Procedure Code	Services	Unit of Service	*Rate per Unit
W0209	Purchase and/or installation, maintenance or repair of a monitoring device, equipment or system	1 unit a year	Actual Cost (maximum of \$1,000)
W0210	Monthly rental cost including monitoring and maintenance of system	1 month	The lesser of \$45.00 or the provider's usual and customary charge to the public/month

Following are specific instructions for billing a Personal Emergency Response Systems under the Waiver for Older Adults.

- Providers must be approved to provide Personal Emergency System services under the Medicaid Waiver for Older Adults.
- A "unit of service" for a Personal Emergency Response System –Device or Equipment (W0209) is one installed unit.
- A "unit of service" for Personal Emergency Response System –Rental, Monitoring and Maintenance of Device or Equipment (W0210) is a month.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care.
- Services may only be provided to waiver participants residing at home.
- See COMAR 10.09.54.09 & .25 for additional information on this service.
- Medicaid will pay the provider the lesser of: \$1000 per unit or the provider's usual and customary charge to the general public for Procedure Code W0209.
- Medicaid will pay the provider the lesser of: \$45.00 or the provider's usual and customary charge to the general public per month for Procedure Code W0210.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an original signature - NO FAXED COPIES ARE ACCEPTED

Sample Claim for Agency Personal Emergency Response System (W0209) and Monthly Rental (W0210)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP		<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER		<input type="checkbox"/> FECA <input type="checkbox"/> OTHER		<input type="checkbox"/> FECA <input type="checkbox"/> OTHER	
1. MEDICARE MEDICAID PRIVATE FECA OTHER		2. PATIENT'S BIRTH DATE		3. INSURER'S ID NUMBER		4. INSURER'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT'S RELATIONSHIP TO INSURED		7. INSURER'S ADDRESS (No. Street)		8. INSURER'S CITY	
9. CITY		10. STATE		11. INSURER'S POLICY NUMBER OR POLICY NUMBER		12. INSURER'S DATE OF BIRTH	
13. ZIP CODE		14. TELEPHONE (Include Area Code)		15. EMPLOYER'S NAME OR SCHOOL NAME		16. EMPLOYER'S ADDRESS (No. Street)	
17. OTHER HEALTH PLAN NAME (Last, First, Middle Initial)		18. PATIENT'S EMPLOYMENT (Current or Former)		19. EMPLOYER'S DATE OF BIRTH		20. EMPLOYER'S CITY	
21. OTHER HEALTH PLAN DATE OF BIRTH		22. AUTO ACCIDENT?		23. EMPLOYER'S NAME OR SCHOOL NAME		24. EMPLOYER'S ADDRESS (No. Street)	
25. OTHER HEALTH PLAN NAME OR PROGRAM NAME		26. OTHER ACCIDENT?		27. EMPLOYER'S CITY		28. EMPLOYER'S STATE	
29. EMPLOYER'S NAME OR PROGRAM NAME		30. RESERVED FOR LOCAL USE		31. IS THERE ANOTHER HEALTH BENEFIT PLAN?		32. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (Include the printed name of the insured or other authorized person)	
33. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		34. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Include the printed name of the insured or other authorized person)		35. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (Include the printed name of the insured or other authorized person)		36. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE (Include the printed name of the insured or other authorized person)	
37. DATE OF CURRENT		38. DATE OF PATIENT'S BIRTH		39. DATE OF PATIENT'S BIRTH		40. DATE OF PATIENT'S BIRTH	
41. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		42. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		43. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		44. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	
45. RESERVED FOR LOCAL USE		46. RESERVED FOR LOCAL USE		47. RESERVED FOR LOCAL USE		48. RESERVED FOR LOCAL USE	
49. SIGNATURE OF ALIEN OR REFUGEE (Check one: A, B, or C in last line)		50. SIGNATURE OF ALIEN OR REFUGEE (Check one: A, B, or C in last line)		51. SIGNATURE OF ALIEN OR REFUGEE (Check one: A, B, or C in last line)		52. SIGNATURE OF ALIEN OR REFUGEE (Check one: A, B, or C in last line)	
53. DATE OF SERVICE		54. DATE OF SERVICE		55. DATE OF SERVICE		56. DATE OF SERVICE	
57. DATE OF SERVICE		58. DATE OF SERVICE		59. DATE OF SERVICE		60. DATE OF SERVICE	
61. DATE OF SERVICE		62. DATE OF SERVICE		63. DATE OF SERVICE		64. DATE OF SERVICE	
65. DATE OF SERVICE		66. DATE OF SERVICE		67. DATE OF SERVICE		68. DATE OF SERVICE	
69. DATE OF SERVICE		70. DATE OF SERVICE		71. DATE OF SERVICE		72. DATE OF SERVICE	
73. DATE OF SERVICE		74. DATE OF SERVICE		75. DATE OF SERVICE		76. DATE OF SERVICE	
77. DATE OF SERVICE		78. DATE OF SERVICE		79. DATE OF SERVICE		80. DATE OF SERVICE	
81. DATE OF SERVICE		82. DATE OF SERVICE		83. DATE OF SERVICE		84. DATE OF SERVICE	
85. DATE OF SERVICE		86. DATE OF SERVICE		87. DATE OF SERVICE		88. DATE OF SERVICE	
89. DATE OF SERVICE		90. DATE OF SERVICE		91. DATE OF SERVICE		92. DATE OF SERVICE	
93. DATE OF SERVICE		94. DATE OF SERVICE		95. DATE OF SERVICE		96. DATE OF SERVICE	
97. DATE OF SERVICE		98. DATE OF SERVICE		99. DATE OF SERVICE		100. DATE OF SERVICE	
101. DATE OF SERVICE		102. DATE OF SERVICE		103. DATE OF SERVICE		104. DATE OF SERVICE	
105. DATE OF SERVICE		106. DATE OF SERVICE		107. DATE OF SERVICE		108. DATE OF SERVICE	
109. DATE OF SERVICE		110. DATE OF SERVICE		111. DATE OF SERVICE		112. DATE OF SERVICE	
113. DATE OF SERVICE		114. DATE OF SERVICE		115. DATE OF SERVICE		116. DATE OF SERVICE	
117. DATE OF SERVICE		118. DATE OF SERVICE		119. DATE OF SERVICE		120. DATE OF SERVICE	
121. DATE OF SERVICE		122. DATE OF SERVICE		123. DATE OF SERVICE		124. DATE OF SERVICE	
125. DATE OF SERVICE		126. DATE OF SERVICE		127. DATE OF SERVICE		128. DATE OF SERVICE	
129. DATE OF SERVICE		130. DATE OF SERVICE		131. DATE OF SERVICE		132. DATE OF SERVICE	
133. DATE OF SERVICE		134. DATE OF SERVICE		135. DATE OF SERVICE		136. DATE OF SERVICE	
137. DATE OF SERVICE		138. DATE OF SERVICE		139. DATE OF SERVICE		140. DATE OF SERVICE	
141. DATE OF SERVICE		142. DATE OF SERVICE		143. DATE OF SERVICE		144. DATE OF SERVICE	
145. DATE OF SERVICE		146. DATE OF SERVICE		147. DATE OF SERVICE		148. DATE OF SERVICE	
149. DATE OF SERVICE		150. DATE OF SERVICE		151. DATE OF SERVICE		152. DATE OF SERVICE	
153. DATE OF SERVICE		154. DATE OF SERVICE		155. DATE OF SERVICE		156. DATE OF SERVICE	
157. DATE OF SERVICE		158. DATE OF SERVICE		159. DATE OF SERVICE		160. DATE OF SERVICE	
161. DATE OF SERVICE		162. DATE OF SERVICE		163. DATE OF SERVICE		164. DATE OF SERVICE	
165. DATE OF SERVICE		166. DATE OF SERVICE		167. DATE OF SERVICE		168. DATE OF SERVICE	
169. DATE OF SERVICE		170. DATE OF SERVICE		171. DATE OF SERVICE		172. DATE OF SERVICE	
173. DATE OF SERVICE		174. DATE OF SERVICE		175. DATE OF SERVICE		176. DATE OF SERVICE	
177. DATE OF SERVICE		178. DATE OF SERVICE		179. DATE OF SERVICE		180. DATE OF SERVICE	
181. DATE OF SERVICE		182. DATE OF SERVICE		183. DATE OF SERVICE		184. DATE OF SERVICE	
185. DATE OF SERVICE		186. DATE OF SERVICE		187. DATE OF SERVICE		188. DATE OF SERVICE	
189. DATE OF SERVICE		190. DATE OF SERVICE		191. DATE OF SERVICE		192. DATE OF SERVICE	
193. DATE OF SERVICE		194. DATE OF SERVICE		195. DATE OF SERVICE		196. DATE OF SERVICE	
197. DATE OF SERVICE		198. DATE OF SERVICE		199. DATE OF SERVICE		200. DATE OF SERVICE	
201. DATE OF SERVICE		202. DATE OF SERVICE		203. DATE OF SERVICE		204. DATE OF SERVICE	
205. DATE OF SERVICE		206. DATE OF SERVICE		207. DATE OF SERVICE		208. DATE OF SERVICE	
209. DATE OF SERVICE		210. DATE OF SERVICE		211. DATE OF SERVICE		212. DATE OF SERVICE	
213. DATE OF SERVICE		214. DATE OF SERVICE		215. DATE OF SERVICE		216. DATE OF SERVICE	
217. DATE OF SERVICE		218. DATE OF SERVICE		219. DATE OF SERVICE		220. DATE OF SERVICE	
221. DATE OF SERVICE		222. DATE OF SERVICE		223. DATE OF SERVICE		224. DATE OF SERVICE	
225. DATE OF SERVICE		226. DATE OF SERVICE		227. DATE OF SERVICE		228. DATE OF SERVICE	
229. DATE OF SERVICE		230. DATE OF SERVICE		231. DATE OF SERVICE		232. DATE OF SERVICE	
233. DATE OF SERVICE		234. DATE OF SERVICE		235. DATE OF SERVICE		236. DATE OF SERVICE	
237. DATE OF SERVICE		238. DATE OF SERVICE		239. DATE OF SERVICE		240. DATE OF SERVICE	
241. DATE OF SERVICE		242. DATE OF SERVICE		243. DATE OF SERVICE		244. DATE OF SERVICE	
245. DATE OF SERVICE		246. DATE OF SERVICE		247. DATE OF SERVICE		248. DATE OF SERVICE	
249. DATE OF SERVICE		250. DATE OF SERVICE		251. DATE OF SERVICE		252. DATE OF SERVICE	
253. DATE OF SERVICE		254. DATE OF SERVICE		255. DATE OF SERVICE		256. DATE OF SERVICE	
257. DATE OF SERVICE		258. DATE OF SERVICE		259. DATE OF SERVICE		260. DATE OF SERVICE	
261. DATE OF SERVICE		262. DATE OF SERVICE		263. DATE OF SERVICE		264. DATE OF SERVICE	
265. DATE OF SERVICE		266. DATE OF SERVICE		267. DATE OF SERVICE		268. DATE OF SERVICE	
269. DATE OF SERVICE		270. DATE OF SERVICE		271. DATE OF SERVICE		272. DATE OF SERVICE	
273. DATE OF SERVICE		274. DATE OF SERVICE		275. DATE OF SERVICE		276. DATE OF SERVICE	
277. DATE OF SERVICE		278. DATE OF SERVICE		279. DATE OF SERVICE		280. DATE OF SERVICE	
281. DATE OF SERVICE		282. DATE OF SERVICE		283. DATE OF SERVICE		284. DATE OF SERVICE	
285. DATE OF SERVICE		286. DATE OF SERVICE		287. DATE OF SERVICE		288. DATE OF SERVICE	
289. DATE OF SERVICE		290. DATE OF SERVICE		291. DATE OF SERVICE		292. DATE OF SERVICE	
293. DATE OF SERVICE		294. DATE OF SERVICE		295. DATE OF SERVICE		296. DATE OF SERVICE	
297. DATE OF SERVICE		298. DATE OF SERVICE		299. DATE OF SERVICE		300. DATE OF SERVICE	
301. DATE OF SERVICE		302. DATE OF SERVICE		303. DATE OF SERVICE		304. DATE OF SERVICE	
305. DATE OF SERVICE		306. DATE OF SERVICE		307. DATE OF SERVICE		308. DATE OF SERVICE	
309. DATE OF SERVICE		310. DATE OF SERVICE		311. DATE OF SERVICE		312. DATE OF SERVICE	
313. DATE OF SERVICE		314. DATE OF SERVICE		315. DATE OF SERVICE		316. DATE OF SERVICE	
317. DATE OF SERVICE		318. DATE OF SERVICE		319. DATE OF SERVICE		320. DATE OF SERVICE	
321. DATE OF SERVICE		322. DATE OF SERVICE		323. DATE OF SERVICE		324. DATE OF SERVICE	
325. DATE OF SERVICE		326. DATE OF SERVICE		327. DATE OF SERVICE		328. DATE OF SERVICE	
329. DATE OF SERVICE		330. DATE OF SERVICE		331. DATE OF SERVICE		332. DATE OF SERVICE	
333. DATE OF SERVICE		334. DATE OF SERVICE		335. DATE OF SERVICE		336. DATE OF SERVICE	
337. DATE OF SERVICE		338. DATE OF SERVICE		339. DATE OF SERVICE		340. DATE OF SERVICE	
341. DATE OF SERVICE		342. DATE OF SERVICE		343. DATE OF SERVICE		344. DATE OF SERVICE	
345. DATE OF SERVICE		346. DATE OF SERVICE		347. DATE OF SERVICE		348. DATE OF SERVICE	
349. DATE OF SERVICE		350. DATE OF SERVICE		351. DATE OF SERVICE		352. DATE OF SERVICE	
353. DATE OF SERVICE		354. DATE OF SERVICE		355. DATE OF SERVICE		356. DATE OF SERVICE	
357. DATE OF SERVICE		358. DATE OF SERVICE		359. DATE OF SERVICE		360. DATE OF SERVICE	
361. DATE OF SERVICE		362. DATE OF SERVICE		363. DATE OF SERVICE		364. DATE OF SERVICE	
365. DATE OF SERVICE		366. DATE OF SERVICE		367. DATE OF SERVICE		368. DATE OF SERVICE	
369. DATE OF SERVICE		370. DATE OF SERVICE		371. DATE OF SERVICE		372. DATE OF SERVICE	
373. DATE OF SERVICE		374. DATE OF SERVICE		375. DATE OF SERVICE		376. DATE OF SERVICE	
377. DATE OF SERVICE		378. DATE OF SERVICE		379. DATE OF SERVICE		380. DATE OF SERVICE	
381. DATE OF SERVICE		382. DATE OF SERVICE		383. DATE OF SERVICE		384. DATE OF SERVICE	
385. DATE OF SERVICE		386. DATE OF SERVICE		387. DATE OF SERVICE		388. DATE OF SERVICE	
389. DATE OF SERVICE		390. DATE OF SERVICE		391. DATE OF SERVICE		392. DATE OF SERVICE	
393. DATE OF SERVICE		394. DATE OF SERVICE		395. DATE OF SERVICE		396. DATE OF SERVICE	
397. DATE OF SERVICE		398. DATE OF SERVICE		399. DATE OF SERVICE		400. DATE OF SERVICE	
401. DATE OF SERVICE		402. DATE OF SERVICE		403. DATE OF SERVICE		404. DATE OF SERVICE	
405. DATE OF SERVICE		406. DATE OF SERVICE		407. DATE OF SERVICE		408. DATE OF SERVICE	
409. DATE OF SERVICE		410. DATE OF SERVICE		411. DATE OF SERVICE		412. DATE OF SERVICE	
413. DATE OF SERVICE		414. DATE OF SERVICE		415. DATE OF SERVICE		416. DATE OF SERVICE	
417. DATE OF SERVICE		418. DATE OF SERVICE		419. DATE OF SERVICE		420. DATE OF SERVICE	
421. DATE OF SERVICE		422. DATE OF SERVICE		423. DATE OF SERVICE		424. DATE OF SERVICE	
425. DATE OF SERVICE		426. DATE OF SERVICE		427. DATE OF SERVICE		428. DATE OF SERVICE	
429. DATE OF SERVICE		430. DATE OF SERVICE		431. DATE OF SERVICE		432. DATE OF SERVICE	
433. DATE OF SERVICE		434. DATE OF SERVICE		435. DATE OF SERVICE		436. DATE OF SERVICE	
437. DATE OF SERVICE		438. DATE OF SERVICE		439. DATE OF SERVICE		440. DATE OF SERVICE	
441. DATE OF SERVICE		442. DATE OF SERVICE		443. DATE OF SERVICE		444. DATE OF SERVICE	
445. DATE OF SERVICE		446. DATE OF SERVICE		447. DATE OF SERVICE		448. DATE OF SERVICE	
449. DATE OF SERVICE		450. DATE OF SERVICE		451. DATE OF SERVICE		452. DATE OF SERVICE	
453. DATE OF SERVICE		454. DATE OF SERVICE		455. DATE OF SERVICE		456. DATE OF SERVICE	
457. DATE OF SERVICE		458. DATE OF SERVICE		459. DATE OF SERVICE		460. DATE OF SERVICE	
461. DATE OF SERVICE		462. DATE OF SERVICE		463. DATE OF SERVICE		464. DATE OF SERVICE	
465. DATE OF SERVICE		466. DATE OF SERVICE		467. DATE OF SERVICE		468. DATE OF SERVICE	
469. DATE OF SERVICE		470. DATE OF SERVICE		471. DATE OF SERVICE		472. DATE OF SERVICE	
473. DATE OF SERVICE		474. DATE OF SERVICE		475. DATE OF SERVICE		476. DATE OF SERVICE	
477. DATE OF SERVICE		478. DATE OF SERVICE		479. DATE OF SERVICE		480. DATE OF SERVICE	
481. DATE OF SERVICE		482. DATE OF SERVICE		483. DATE OF SERVICE		484. DATE OF SERVICE	
485. DATE OF SERVICE		486. DATE OF SERVICE		487. DATE OF SERVICE		488. DATE OF SERVICE	
489. DATE OF SERVICE		490. DATE OF SERVICE		491. DATE OF SERVICE		492. DATE OF SERVICE	
493. DATE OF SERVICE		494. DATE OF SERVICE		495. DATE OF SERVICE		496. DATE OF SERVICE	
497. DATE OF SERVICE		498. DATE OF SERVICE		499. DATE OF SERVICE		500. DATE OF SERVICE	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0233-0599 FORM CMS-1500 (08/00)

Respite Care

Self-Employed Respite Care Aide

Procedure Code	Services	Unit of Service	*Rate per Unit
W0205	Self-Employed Respite Care Aide	1 hour	\$9.97 per Hour

Following are specific instructions for billing for Self-Employed Respite Care Aides under the Waiver for Older Adults:

- A Respite Care aide must be enrolled as a self-employed personal care aide and a self-employed respite care provider under the Medicaid Waiver.
- A "unit of service" is one hour (no partial hour increments are accepted)
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- These services can only be provided to approved Waiver participants residing at home
- Self employed Respite Care aides must possess the following minimum qualifications:
 - A valid Medicaid Waiver provider number
 - Current First Aid and CPR (it is your responsibility to maintain these certifications)
 - Ability to understand the instructions in the participant's plan of care, specific service plan (Caregiver Service Plan) and perform required duties satisfactorily in the presence of a licensed registered nurse.
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an original signature - NO FAXED COPIES ARE ACCEPTED

- NOTE: 1. Medicaid will pay for no more than 12 hours of respite care services in a 24 hour period under Procedure Code W0205.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Agency Employed Respite Care

Procedure Code	Services	Unit of Service	*Rate per Unit
W0206	Agency - Employed Respite Care Aide	1 hour	\$12.75 per hour

Following are specific instructions for billing for Agency-Employed Respite Care Aides under the Waiver for Older Adults:

- A provider must be enrolled to provide personal care services **and** respite care services under the Medicaid Waiver.
- A "unit of service" is one hour (no partial hour increments are accepted)*.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care

- These services can only be provided to approved Waiver participants residing at home
- Agency Employed Respite Care aides must possess the following minimum qualifications:
 - A valid Medicaid Waiver provider number
 - Current First Aid and CPR (it is your responsibility to maintain these certifications)
 - Ability to understand the instructions in the participant's plan of care, specific service plan (Caregiver Service Plan) and perform required duties satisfactorily in the presence of a licensed registered nurse.
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Provider may only bill for units of services actually provided, not to exceed those specified in the participant's approved Plan of Care.
- Requests for reimbursement must include a copy of a DHMH 4659 – Caregiver Timesheet and, either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

- *NOTE: 1. Medicaid will pay for no more than 12 hours of respite care services in a 24 hour period under Procedure Code W0206.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Respite Care in a Nursing Facility

Procedure Code	Services	Unit of Service	*Rate per Unit
W0220	Respite Care in a Nursing Facility	1 day	\$132.91 per day

Following are specific instructions for billing Respite Care in a Nursing Facility under the Waiver for Older Adults:

- The facility must be enrolled to provide Respite Care Services under the Medicaid Waiver for Older Adults
- A "unit of service" is one (1) day up to a maximum of 14 days per year
- Services can only be provided to approved Waiver participants This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- This service can only be provided to approved Waiver participants residing at home
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Medicaid will pay the provider the lesser of: \$135.62 /day or the provider's usual and customary charge for the general public. Note: Respite care services are provided on a short-term basis and must be administered according to the client's plan of care.
- Provider may only bill for units of services actually provided, not to exceed those specified in the Participant's approved Plan of Care.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

- Note: 1. Medicaid will pay for no more than 14 day of respite care services in a 12 month period under Procedure Code W0220.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Respite Care in an Assisted Living Facility

Procedure Code	Services	Unit of Service	*Rate per Unit
W0221	Respite Care Assisted Living Facility	1 day	\$70.88 per day

Following are specific instructions for billing Respite Care in an Assisted Living Facility under the Waiver for Older Adults:

- A provider must be enrolled to provide Assisted Living Services and Respite Care Services under the Medicaid Waiver for Older Adults
- A "unit of service" is one day up to a maximum of 14 days per year.
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- This service can only be provided to approved Waiver participants residing at home
- See COMAR 10.09.54.07 & .23 for additional information on this service.
- Medicaid will pay the provider the lesser of: \$72.33 per day or the provider's usual and customary charge for the general public. Note: Respite care services are provided on a short-term basis and must be administered according to the participant's Plan of Care.
- Provider may only bill for units of services actually provided, not to exceed those specified in the Participant's approved Plan of Care.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form** (*Appendix B*) with an **original signature** - NO FAXED COPIES ARE ACCEPTED

NOTE: 1. Medicaid will pay for no more than 14 day of respite care services in a 12 month period under Procedure Code W0221.
2. Medicaid will pay for no more than 168 hours of in-home respite care or 14 days in an assisted living facility or nursing home enrolled to provide respite care in a 12 month period. The 12 month period is based on a calendar year.

Sample Claim for Self –Employed Personal Care Aide Enrolled to Provide Respite Care

<div>1500</div> HEALTH INSURANCE CLAIM FORM <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)</small>											
<div>1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PRIVATE GROUP <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> OTHER <input type="checkbox"/> <input type="checkbox"/></div>											
<div>2. PATIENT'S NAME (Last, First, Middle Initial)</div> Doe, John				<div>3. PATIENT'S BIRTH DATE</div> 01/22/29				<div>4. INSURED'S NAME (Last, First, Middle Initial)</div> Doe, John			
<div>5. PATIENT'S ADDRESS (No. & Street)</div> 100 Center Street				<div>6. PATIENT'S RELATIONSHIP TO INSURED</div> Self				<div>7. INSURED'S ADDRESS (No. & Street)</div> 100 Center Street			
<div>8. CITY</div> Baltimore, MD				<div>9. PATIENT STATUS</div> Single				<div>10. CITY</div> Baltimore, MD			
<div>11. ZIP CODE</div> 21200				<div>12. TELEPHONE (Area Code & Number)</div> (410) 333-3333				<div>13. ZIP CODE</div> 21200			
<div>14. OTHER INSURED'S NAME (Last, First, Middle Initial)</div> None				<div>15. INSURED'S EMPLOYER'S NAME</div> None				<div>16. INSURED'S POLICY NUMBER</div> K			
<div>17. INSURED'S DATE OF BIRTH</div> 01/22/29				<div>18. INSURED'S SEX</div> Male				<div>19. EMPLOYER'S NAME ON POLICY</div> None			
<div>20. EMPLOYER'S NAME ON SCHOOL</div> None				<div>21. INSURED'S PLAN NAME OR PROGRAM NAME</div> None				<div>22. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> No			
<div>23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</div> [Signature]											
<div>24. DATE OF SIGNATURE</div> 01/22/29											
<div>25. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div> None											
<div>26. RESERVED FOR LOCAL USE</div>											
<div>27. OWNERS OR PARTNERS OF ALIEN OR RESIDENT (Check one)</div> None											
<div>28. DATE OF SERVICE</div> 01/22/29											
<div>29. MEDICAL CODE</div> W0205											
<div>30. CHARGE</div> \$80											
<div>31. DATE OF SERVICE</div> 01/22/29											
<div>32. MEDICAL CODE</div> W0205											
<div>33. CHARGE</div> \$80											
<div>34. DATE OF SERVICE</div> 01/22/29											
<div>35. MEDICAL CODE</div> W0205											
<div>36. CHARGE</div> \$80											
<div>37. DATE OF SERVICE</div> 01/22/29											
<div>38. MEDICAL CODE</div> W0205											
<div>39. CHARGE</div> \$80											
<div>40. DATE OF SERVICE</div> 01/22/29											
<div>41. MEDICAL CODE</div> W0205											
<div>42. CHARGE</div> \$80											
<div>43. DATE OF SERVICE</div> 01/22/29											
<div>44. MEDICAL CODE</div> W0205											
<div>45. CHARGE</div> \$80											
<div>46. DATE OF SERVICE</div> 01/22/29											
<div>47. MEDICAL CODE</div> W0205											
<div>48. CHARGE</div> \$80											
<div>49. DATE OF SERVICE</div> 01/22/29											
<div>50. MEDICAL CODE</div> W0205											
<div>51. CHARGE</div> \$80											
<div>52. DATE OF SERVICE</div> 01/22/29											
<div>53. MEDICAL CODE</div> W0205											
<div>54. CHARGE</div> \$80											
<div>55. DATE OF SERVICE</div> 01/22/29											
<div>56. MEDICAL CODE</div> W0205											
<div>57. CHARGE</div> \$80											
<div>58. DATE OF SERVICE</div> 01/22/29											
<div>59. MEDICAL CODE</div> W0205											
<div>60. CHARGE</div> \$80											
<div>61. DATE OF SERVICE</div> 01/22/29											
<div>62. MEDICAL CODE</div> W0205											
<div>63. CHARGE</div> \$80											
<div>64. DATE OF SERVICE</div> 01/22/29											
<div>65. MEDICAL CODE</div> W0205											
<div>66. CHARGE</div> \$80											
<div>67. DATE OF SERVICE</div> 01/22/29											
<div>68. MEDICAL CODE</div> W0205											
<div>69. CHARGE</div> \$80											
<div>70. DATE OF SERVICE</div> 01/22/29											
<div>71. MEDICAL CODE</div> W0205											
<div>72. CHARGE</div> \$80											
<div>73. DATE OF SERVICE</div> 01/22/29											
<div>74. MEDICAL CODE</div> W0205											
<div>75. CHARGE</div> \$80											
<div>76. DATE OF SERVICE</div> 01/22/29											
<div>77. MEDICAL CODE</div> W0205											
<div>78. CHARGE</div> \$80											
<div>79. DATE OF SERVICE</div> 01/22/29											
<div>80. MEDICAL CODE</div> W0205											
<div>81. CHARGE</div> \$80											
<div>82. DATE OF SERVICE</div> 01/22/29											
<div>83. MEDICAL CODE</div> W0205											
<div>84. CHARGE</div> \$80											
<div>85. DATE OF SERVICE</div> 01/22/29											
<div>86. MEDICAL CODE</div> W0205											
<div>87. CHARGE</div> \$80											
<div>88. DATE OF SERVICE</div> 01/22/29											
<div>89. MEDICAL CODE</div> W0205											
<div>90. CHARGE</div> \$80											
<div>91. DATE OF SERVICE</div> 01/22/29											
<div>92. MEDICAL CODE</div> W0205											
<div>93. CHARGE</div> \$80											
<div>94. DATE OF SERVICE</div> 01/22/29											
<div>95. MEDICAL CODE</div> W0205											
<div>96. CHARGE</div> \$80											
<div>97. DATE OF SERVICE</div> 01/22/29											
<div>98. MEDICAL CODE</div> W0205											
<div>99. CHARGE</div> \$80											
<div>100. DATE OF SERVICE</div> 01/22/29											

Sample Claim for Agency Personal Care Provider Enrolled to Provide Respite Care Service

WAIVER FOR OLDER ADULT BILLING CLAIM FORM <small>**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agencies on Aging</small>																																	
Participant's Name: John Doe Address: 100 Center Street City: Baltimore State: Maryland Zip: 21200 Telephone: 410-333-3333				Participant's Medical Number <table border="1" style="width: 100%; text-align: center;"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>0</td> </tr> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								0	1	2	3	4	5	6	7	8	9	0											
				0	1	2	3	4	5	6	7	8	9	0																			
Participant Birth Date: <table border="1" style="width: 100%; text-align: center;"> <tr> <td>MM</td><td>DD</td><td>YYYY</td> </tr> <tr> <td>1</td><td>22</td><td>1929</td> </tr> </table>				MM	DD	YYYY	1	22	1929	Insurance Policy Group: K		Participant's Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female																					
MM	DD	YYYY																															
1	22	1929																															
Dates Billed <table border="1" style="width: 100%; text-align: center;"> <tr> <td>MM</td><td>DD</td><td>YY</td> </tr> <tr> <td>01</td><td>01</td><td>03</td> </tr> </table>		MM	DD	YY	01	01	03	Place of Service ALP=12 PC=12		Waiver Procedure Code W203		Charges 129		Day/Units 40 / 10																			
MM	DD	YY																															
01	01	03																															
1																																	
2																																	
3																																	
4																																	
5																																	
6																																	
7																																	
8																																	
9																																	
10																																	
11																																	
12																																	
13																																	
14																																	
15																																	
16																																	
17																																	
18																																	
19																																	
20																																	
21																																	
22																																	
23																																	
24																																	
25																																	
26																																	
27																																	
28																																	
29																																	
30																																	
31																																	
Your Original Signature: PROVIDER SIGNATURE				PROVIDER/FACILITY NAME: ABC AGENCY 800 MOUNT STREET PROVIDER ADDRESS:				\$ 1290.00 TOTAL AMOUNT		TOTAL UNITS																							
DATE				CITY, STATE, ZIP: BALTIMORE MD, 21200				TELEPHONE: 410-333-3333																									
				PROVIDER #																													
<small>(AAA) Claims Processor</small>																																	

MDOA 6-27-07-FINAL

Sample Claim for Assisted Living Facility Enrolled to Provide Respite Care Service

WAIVER FOR OLDER ADULT BILLING CLAIM FORM **VALID ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging																															
Participant's Name : John Doe				Participant's Medicaid Number																											
Address: 100 Center Street				<table border="1"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>								0	1	2	3	4	5	6	7	8	9										
0	1	2	3	4	5	6	7	8	9																						
City Baltimore		State Maryland		Participant Birth Date			Insured's Policy Group		Participant's Sex																						
Zip 21201		Telephone 410-333-3333		<table border="1"> <tr> <td>Mm</td><td>Dd</td><td>Yyyy</td> </tr> <tr> <td>1</td><td>22</td><td>1929</td> </tr> </table>			Mm	Dd	Yyyy	1	22	1929	K		<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female																
Mm	Dd	Yyyy																													
1	22	1929																													
<table border="1"> <tr> <th rowspan="2"></th> <th colspan="3">Dates Billed</th> <th colspan="2">Place of Service</th> <th rowspan="2">Waiver Procedure Code</th> <th colspan="2">Charges</th> <th colspan="2">Day/Units</th> </tr> <tr> <th>MM</th> <th>DD</th> <th>YY</th> <th>ALP=03</th> <th>PC=12</th> <th></th> <th></th> <th></th> <th></th> </tr> </table>					Dates Billed			Place of Service		Waiver Procedure Code	Charges		Day/Units		MM	DD	YY	ALP=03	PC=12												
	Dates Billed				Place of Service		Waiver Procedure Code	Charges			Day/Units																				
	MM	DD	YY	ALP=03	PC=12																										
1	01	01	03	03		W0221	71	57	1	1																					
2	01	02	03	03		W0221	71	57	1	2																					
3	01	03	03	03		W0221	71	57	1	3																					
4		04	03	03		W0221	71	57	1	4																					
5	01	05	03	03		W0221	71	57	1	5																					
6	01	06	03	03		W0221	71	57	1	6																					
7	01	07	03	03		W0221	71	57	1	7																					
8	01	08	03	03		W0221	71	57	1	8																					
9	01	09	03	03		W0221	71	57	1	9																					
10	01	10	03	03		W0221	71	57	1	10																					
11										11																					
12										12																					
13										13																					
14										14																					
15										15																					
16										16																					
17										17																					
18										18																					
19										19																					
20										20																					
21										21																					
22										22																					
23										23																					
24										24																					
25										25																					
26										26																					
27										27																					
28										28																					
29										29																					
30										30																					
31										31																					
Your Original Signature PROVIDER SIGNATURE				PROVIDER/FACILITY NAME: ABC AGENCY 500 MOUNT STREET PROVIDER ADDRESS				\$ 719.70 TOTAL AMOUNT		TOTAL UNITS																					
Today's Date DATE				CITY, STATE, ZIP BALTIMORE, MD, 21201 PROVIDER #				TELEPHONE 410-333-3333																							
				5 5 9 9 9 9 9 9 9 9																											

(AAA) Claims Processor

MDQA-6-07-07-FINAL

Senior Center Plus

Procedure Code	Services	Unit of Service	Rate per Unit
W1723	Senior Center Plus	1 day	\$44.31 per day

Following are specific instructions for billing Senior Center Plus services under the Waiver for Older Adults.

- The facility must be enrolled as a Senior Center Plus provider under the Waiver for Older Adults.
- A "unit of service" is a day of attendance for at least 4 hours, and includes at least one meal (and a snack if the day program exceeds 6 hours).
- This service, the provider and the units of service must be listed in the participant's approved Plan of Care
- Senior Center Plus services may be provided to waiver participants residing either at home or in an assisted living facility.
- See COMAR 10.09.54.05 D & .21 for additional information on this service
- Medicaid will pay the provider the lesser of: \$45.21 per day or the provider's usual and customary charge for the general public.
- Requests for reimbursement must be submitted on either a CMS 1500 Claim Form or the **Modified Billing Form (Appendix B)** with an **original signature** - NO FAXED COPIES ARE ACCEPTED

Note: Medicaid will not pay for both Senior Center Plus and Medicaid State Plan day care for a waiver participant on the same date.

APPENDIX A
CAREGIVER TIMESHEET
(DHMH-4659)

**Medicaid Home and Community-Based Services Waiver Program
Caregiver Time Sheet/Caregiver Service Record Form**

Waiver Program: ☐ Waiver for Elder Abuse (WEA) ☐ Living at Home Waiver (LAH)

Waiver Participant Name (Print) _____ Caregiver/Standard Personal Care (Print) _____

Check appropriate box: Provider Type: ☐ Independent ☐ Agency _____ (optional)

Day	Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours	Participant Initials
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

Participant Representative's Signature _____ Date _____

Provider's Signature _____ Date _____

By signing above, the caregiver certifies the services rendered are in accordance with the individual Plan of Service/Plan of Care on the above date of service as specified in the Caregiver Service Plan and that the caregiver delivered to the participant all services hours listed on this form.

Mark "YES" or "NO" in the boxes next to the task to show when you did or not on each day.

Task	Sun	Mon	Tue	Wed	Thurs	Fri	Sat	Comments
Personal Hygiene (i.e. bathing, hair care, nail, and skin care)								
Toileting (i.e. bladder, bowel, and genital continence management including bathroom)								
Dressing & Changing Clothes								
Medication & Treatment								
Eating & Drinking								
Mobility/Aids								
Light Housekeeping (e.g. Laundry)								
Meals								
Other (please specify):								

Independent caregiver - Attach the other copy of this signed document to the appropriate program billing form (LAH - BRENH 2550 or WEA - CMS 1500) to bill for payment.

Agency caregiver - Submit the other copy of this signed document to your agency. They will attach the other copy of the form check to the appropriate billing form and forward the documents to the billing department for payment.

Dependent caregiver - Attach the other copy of this signed document to the appropriate program billing form (LAH - BRENH 2550 or WEA - CMS 1500) to bill for payment.

Dependent caregiver - Attach the other copy of this signed document to the appropriate program billing form (LAH - BRENH 2550 or WEA - CMS 1500) to bill for payment.

BRENH 2550, 6C - 73; Approval 07/01/00

White Copy - Billing Department

White Copy - Home Manager

White Copy - Participant Representative

Yellow Copy - Caregiver

APPENDIX B

MODIFIED BILLING FORM

WAIVER FOR OLDER ADULT BILLING CLAIM FORM

Participant's Name (Last Name, First Name, MI)						Participant's Medicaid Number									
Address															
City			State			Participant Birth Date			Insured's Policy Group			Participant's Sex:			
Zip			Telephone			MM DD YYYY			K			<input type="checkbox"/> Male <input type="checkbox"/> Female			
Date Billed		Place Of Service		Waiver Procedure Code		Charges		Day/Units							
MM	DD	YY	ALP=03	PC=12											
1												1			
2												2			
3												3			
4												4			
5												5			
6												6			
7												7			
8												8			
9												9			
10												10			
11												11			
12												12			
13												13			
14												14			
15												15			
16												16			
17												17			
18												18			
19												19			
20												20			
21												21			
22												22			
23												23			
24												24			
25												25			
26												26			
27												27			
28												28			
29												29			
30												30			
31												31			
PROVIDER SIGNATURE				PROVIDER/FACILITY NAME				\$		TOTAL CHARGES		TOTAL UNITS			
				PROVIDER ADDRESS											
DATE				CITY, STATE, ZIP				TELEPHONE							
				PROVIDER#											

**Valid ONLY for Waiver for Older Adults claims submitted to the Maryland Department of Aging (MDOA) and Area Agency on Aging (AAA) Claims Processors

MDQA-6-27-07- FINAL

APPENDIX C
NURSE MONITOR TIMESHEET
(DHMH-4658D)

**Medicaid Home and Community-Based Services Waiver Programs
Name Monitor Time Sheet (use only for people at home)**

Waiver Program ☐ Waiver for Older Adults (WOA) ☐ Living at Home Waiver (LAH)

Participant's Name (Print) _____

Name Monitor's Name (Print) _____

Please check all applicable boxes below:

Provider Type: ☐ Agency _____ (Name) ☐ Independent

Type of visit: Waiver for Older Adults Living at Home Waiver

☐ Initial Visit ☐ Initial Visit ☐ 4 Month Visit
☐ Monthly Visit ☐ 45 Day Visit ☐ Other _____
☐ Other _____ (non frequency) ☐ 3 Month Visit (non frequency)

Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours

Participant and Provider Certification - Please carefully read, date and sign this section.

By signing this document, the Name Monitor certifies that the delegated nursing functions, participant assessment and caregiver performance is in accordance with the authorized Plan of Service/Care. The name monitor and participant also certify that the name monitor provided the service hours on the date listed on this form.

Participant's Representative's Signature _____

Date _____

Name Monitor's Signature _____

Date _____

LAH - Independent name monitor - Attach the white copy of this signed document to the appropriate program Billing form (LAH - DHMH 4550.) Send both forms to the billing department for payment.
LAH and WOA - Agency name monitor - Submit the white copy of this signed time sheet to your agency. They will attach the white copy of this document to the appropriate billing document for payment.

Immediately upon any serious issue or participant needs to the Living at Home Waiver 1-877-655-5558 or the Waiver for Older Adults 1-800-261-7424.

Immediately report suspected abuse, neglect or exploitation to Adult Protective Services at 1-800-917-7354. Report any serious health or safety concerns to the case manager.

DHMH-4550 (4-75) Approved 7/2000

White Copy - Billing Department

Yellow Copy - Name Monitor

Pink Copy - Participant Representative

APPENDIX D
CMS-1500 BILLING FORM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE/USE

1. MEDICARE										2. MEDICAID										3. PRIVATE INSURANCE										4. CHAMPVA										5. COMB. MEDICAL PLAN										6. FICA/UNEMP										7. OTHER										8. SURGEON'S ID. NUMBER																													
Medicare #										Medicaid #										Policy #										Member ID #										Plan #										FICA/UNEMP #										Other #										For Program in Item 1																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)																																								3. PATIENT'S BIRTH DATE										4. SEX										5. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
6. PATIENT'S ADDRESS (St., Street)																																								7. PATIENT'S RELATIONSHIP TO INSURED										8. INSURED'S ADDRESS (St., Street)																																																	
CITY																				STATE																				9. PATIENT STATUS										CITY																				STATE																													
ZIP CODE																				TELEPHONE (Include Area Code)																				10. IS PATIENT'S CONDITION RELATED TO?										11. INSURED'S POLICY GROUP OR PROGRAM NUMBER																																																	
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																																								13. EMPLOYMENT (Current or Past)										14. INSURED'S DATE OF BIRTH																																																	
15. OTHER INSURED'S DATE OF BIRTH																																								16. AUTO ACCIDENT?										17. EMPLOYER'S NAME OR SCHOOL NAME										18. INSURED'S DATE OF BIRTH																																							
19. EMPLOYER'S NAME OR SCHOOL NAME																																								20. OTHER ACCIDENT?										21. INSURANCE PLAN NAME OR PROGRAM NAME										22. EMPLOYER'S NAME OR SCHOOL NAME																																							
23. INSURANCE PLAN NAME OR PROGRAM NAME																																								24. RESERVED FOR LOCAL USE										25. IS THERE ANOTHER HEALTH INSURANCE PLAN?										26. INSURED'S CHARTERED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)																																							
27. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of my record or the information necessary to process this claim. I also request payment of payment benefits either to myself or to the party who completes this form.)																																								28. DATE										29. DATE																																																	
30. DATE OF CURRENT CLAIM (Date of Injury or Date of Illness)																																								31. IF PATIENT HAS HAD ANOTHER CLAIM, LIST DATE										32. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																																																	
33. NAME OF PROVIDING PROVIDER OR OTHER SOURCE																																								34. DATE										35. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE																																																	
36. RESERVED FOR LOCAL USE																																								37. DATE										38. OUTSIDE LAG?																																																	
39. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Attach Item 1, 2, 3, 4 & 5 from Item 1)																																								40. DATE										41. MEDICAL RESURSION CODE																																																	
42. DATE																																								43. DATE										44. PRIOR AUTHORIZATION NUMBER																																																	
45. DATE																																								46. DATE										47. DATE																																																	
48. DATE																																								49. DATE										50. DATE																																																	
51. DATE																																								52. DATE										53. DATE																																																	
54. DATE																																								55. DATE										56. DATE																																																	
57. DATE																																								58. DATE										59. DATE																																																	
60. DATE																																								61. DATE										62. DATE																																																	
63. DATE																																								64. DATE										65. DATE																																																	
66. DATE																																								67. DATE										68. DATE																																																	
69. DATE																																								70. DATE										71. DATE																																																	
72. DATE																																								73. DATE										74. DATE																																																	
75. DATE																																								76. DATE										77. DATE																																																	
78. DATE																																								79. DATE										80. DATE																																																	
81. DATE																																								82. DATE										83. DATE																																																	
84. DATE																																								85. DATE										86. DATE																																																	
87. DATE																																								88. DATE										89. DATE																																																	
90. DATE																																								91. DATE										92. DATE																																																	
93. DATE																																								94. DATE										95. DATE																																																	
96. DATE																																								97. DATE										98. DATE																																																	
99. DATE																																								100. DATE										101. DATE																																																	
102. DATE																																								103. DATE										104. DATE																																																	
105. DATE																																								106. DATE										107. DATE																																																	
108. DATE																																								109. DATE										110. DATE																																																	
111. DATE																																								112. DATE										113. DATE																																																	
114. DATE																																								115. DATE										116. DATE																																																	
117. DATE																																								118. DATE										119. DATE																																																	
120. DATE																																								121. DATE										122. DATE																																																	
123. DATE																																								124. DATE										125. DATE																																																	
126. DATE																																								127. DATE										128. DATE																																																	
129. DATE																																								130. DATE										131. DATE																																																	
132. DATE																																								133. DATE										134. DATE																																																	
135. DATE																																								136. DATE										137. DATE																																																	
138. DATE																																								139. DATE										140. DATE																																																	
141. DATE																																								142. DATE										143. DATE																																																	
144. DATE																																								145. DATE										146. DATE																																																	
147. DATE																																								148. DATE										149. DATE																																																	
150. DATE																																								151. DATE										152. DATE																																																	
153. DATE																																								154. DATE										155. DATE																																																	
156. DATE																																								157. DATE										158. DATE																																																	
159. DATE																																								160. DATE										161. DATE																																																	
162. DATE																																								163. DATE										164. DATE																																																	
165. DATE																																								166. DATE										167. DATE																																																	
168. DATE																																								169. DATE										170. DATE																																																	
171. DATE																																								172. DATE										173. DATE																																																	
174. DATE																																								175. DATE										176. DATE																																																	
177. DATE																																								178. DATE										179. DATE																																																	
180. DATE																																								181. DATE										182. DATE																																																	
183. DATE																																								184. DATE										185. DATE																																																	
186. DATE																																								187. DATE										188. DATE																																																	
189. DATE																																								190. DATE										191. DATE																																																	
192. DATE																																								193. DATE										194. DATE																																																	
195. DATE																																								196. DATE										197. DATE																																																	
198. DATE																																								199. DATE										200. DATE																																																	
201. DATE																																								202. DATE										203. DATE																																																	
204. DATE																																								205. DATE										206. DATE																																																	
207. DATE																																								208. DATE										209. DATE																																																	
210. DATE																																								211. DATE										212. DATE																																																	
213. DATE																																								214. DATE										215. DATE																																																	
216. DATE																																								217. DATE										218. DATE																																																	
219. DATE																																								220. DATE										221. DATE																																																	
222. DATE																																								223. DATE										224. DATE																																																	
225. DATE																																								226. DATE										227. DATE																																																	
228. DATE																																								229. DATE										230. DATE																																																	
231. DATE																																								232. DATE										233. DATE																																																	
234. DATE																																								235. DATE										236. DATE																																																	
237. DATE																																								238. DATE										239. DATE																																																	
240. DATE																																								241. DATE										242. DATE																																																	
243. DATE																																								244. DATE										245. DATE																																																	
246. DATE																																								247. DATE										248. DATE																																																	
249. DATE																																								250. DATE										251. DATE																																																	
252. DATE																																								253. DATE										254. DATE																																																	
255. DATE																																								256. DATE										257. DATE																																																	
258. DATE																																								259. DATE										260. DATE																																																	
261. DATE																																								262. DATE										263. DATE																																																	
264. DATE																																								265. DATE										266. DATE																																																	
267. DATE																																								268. DATE										269. DATE																																																	
270. DATE																																								271. DATE										272. DATE																																																	
273. DATE																																								274. DATE										275. DATE																																																	
276. DATE																																								277. DATE										278. DATE																																																	
279. DATE																																								280. DATE										281. DATE																																																	
282. DATE																																								283. DATE										284. DATE																																																	
285. DATE																																								286. DATE										287. DATE																																																	
288. DATE																																								289. DATE										290. DATE																																																	
291. DATE																																								292. DATE										293. DATE																																																	
294. DATE																																								295. DATE										296. DATE																																																	
297. DATE																																								298. DATE										299. DATE																																																	
300. DATE																																								301. DATE										302. DATE																																																	
303. DATE																																								304. DATE										305. DATE																																																	
306. DATE																																								307. DATE										308. DATE																																																	
309. DATE																																								310. DATE										311. DATE																																																	
312. DATE																																								313. DATE										314. DATE																																																	
315. DATE																																								316. DATE										317. DATE																																																	
318. DATE																																								319. DATE										320. DATE																																																	
321. DATE																																								322. DATE										323. DATE																																																	
324. DATE																																								325. DATE										326. DATE																																																	
327. DATE																																								328. DATE										329. DATE																																																	
330. DATE																																								331. DATE										332. DATE																																																	
333. DATE																																								334. DATE										335. DATE																																																	
336. DATE																																								337. DATE										338. DATE																																																	
339. DATE																																								340. DATE										341. DATE																																																	
342. DATE																																								343. DATE										344. DATE																																																	
345. DATE																																								346. DATE										347. DATE																																																	
348. DATE																																								349. DATE										350. DATE																																																	
351. DATE																																								352. DATE										353. DATE																																																	
354. DATE																																								355. DATE										356. DATE																																																	
357. DATE																																								358. DATE										359. DATE																																																	
360. DATE																																								361. DATE										362. DATE																																																	
363. DATE																																								364. DATE										365. DATE																																																	
366. DATE																																								367. DATE										368. DATE																																																	
369. DATE																																								370. DATE										371. DATE																																																	
372. DATE																																								373. DATE										374. DATE																																																	
375. DATE																																								376. DATE										377. DATE																																																	
378. DATE																																								379. DATE										380. DATE																																																	
381. DATE																																								382. DATE										383. DATE																																																	
384. DATE																																								385. DATE										386. DATE																																																	
387. DATE																																								388. DATE										389. DATE																																																	
390. DATE																																								391. DATE										392. DATE																																																	
393. DATE																																								394. DATE										395. DATE																																																	
396. DATE																																								397. DATE										398. DATE																																																	
399. DATE																																								400. DATE										401. DATE																																																	
402. DATE																																								403. DATE										404. DATE																																																	
405. DATE																																								406. DATE										407. DATE																																																	
408. DATE																																								409. DATE										410. DATE																																																	
411. DATE																																								412. DATE										413. DATE																																																	
414. DATE																																								415. DATE										416. DATE																																																	
417. DATE																																								418. DATE										419. DATE																																																	
420. DATE																																								421. DATE										422. DATE																																																	
423. DATE																																								424. DATE										425. DATE																																																	
426. DATE																																								427. DATE										428. DATE																																																	
429. DATE																																								430. DATE										431. DATE																																																	
432. DATE																																								433. DATE										434. DATE																																																	
435. DATE																																								436. DATE										437. DATE																																																	
438. DATE																																								439. DATE										440. DATE																																																	
441. DATE																																								442. DATE										443. DATE																																																	
444. DATE																																								445. DATE										446. DATE																																																	
447. DATE																																								448. DATE										449. DATE																																																	
450. DATE																																								451. DATE										452. DATE																																																	
453. DATE																																								454. DATE										455. DATE																																																	
456. DATE																																								457. DATE										458. DATE																																																	
459. DATE																																								460. DATE										461. DATE																																																	
462. DATE																																								463. DATE										464. DATE																																																	
465. DATE																																								466. DATE										467. DATE																																																	
468. DATE																																								469. DATE										470. DATE																																																	
471. DATE																																								472. DATE										473. DATE																																																	
474. DATE																																								475. DATE										476. DATE																																																	
477. DATE																																								478. DATE										479. DATE																																																	
480. DATE																																								481. DATE										482. DATE																																																	
483. DATE																																								484. DATE										485. DATE																																																	
486. DATE																																								487. DATE										488. DATE																																																	
489. DATE																																								490. DATE										491. DATE																																																	
492. DATE																																								493. DATE										494. DATE																																																	
495. DATE																																								496. DATE										497. DATE																																																	
498. DATE																																								499. DATE										500. DATE																																																	

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0382-0392 FORM CMB-1900 (DSCG)

APPENDIX E

AAA Contact Information

Local Departments of Aging

Allegany County

Lynn Marlowe
HRDC, Inc.
19 Frederick Street
Cumberland, MD 21502
301-777-5970, ext. 144
301-777-1685

Anne Arundel County

Therese Tobiczky
Anne Arundel County Dept. of Aging
2666 Riva Road, Suite 400
Annapolis, MD 21401
410-222-4464
410-222-4358 FAX

Baltimore City

Teresa Jeter-Cutting
Baltimore City Commission on Aging
10 N. Calvert Street, Suite 300
Baltimore, MD 21202
410-396-4932
410-545-7805 FAX

Baltimore County

Michael Lehmuth
Baltimore County Dept. of Aging
611 Central Avenue
Towson, MD 21204
410-887-8739
410-887-8796 FAX

MAC Incorporated

Kathy Walker
1504 Riverside Drive
Salisbury, MD 21801
410-742-0505 ext. 108
410-742-0525 FAX ext. 138

Montgomery County

Mario Wawrzusin
Montgomery County
Division of Aging & Disability Services
401 Hungerford Drive, 2nd Floor
Rockville, MD 20850
240-777-3851
240-777-3183 FAX

Prince George's County

Carole Taliaferro
Prince George's County Dept.
of Family Services
6420 Allentown Road, Room 12
Camp Springs, MD 20748
301-265-8450
301-248-5362 FAX

Calvert County

Susan Hance
Calvert County Office on Aging
450 West Dares Beach Road
Prince Frederick, MD 20678
410-535-4606
410-535-1903 FAX

Carroll County

Cindy Howe
Carroll County Bureau of Aging
125 Stoner Avenue
410-386-3820
410-840-1968 FAX

Cecil County

Bob Dermott
Cecil County Dept. of Aging
214 North Street
Elkton, MD 21921
410-996-8438
410-996-5232 FAX

Charles County

Bonnie Hampton
Charles County Dept. of Community Svcs.
8190 Port Tobacco Road
Port Tobacco, MD 20677
301-934-9305 ext. 5145
301-934-0126 FAX

Queen Anne's County

Linda Carney
Queen Anne's Co. Dept. of Aging
104 Powell Street
Centreville, MD 21617
410-758-0848
410-758-4489 Fax

St. Mary's County Office on Aging

Rebecca Kessler
St. Mary's Co. Office on Aging
Garvey Senior Center
P.O. Box 653
Leonardtown, MD
301-475-4200, EXT. 1057
301-475-4503 Fax

Upper Shore Aging

Kathleen Garson
Waiver Unit Manager
Upper Shore Aging, Inc
100 Schaubert Road
Chestertown, MD 21620
410-778-3817
410-778-3562 Fax

Frederick County

Dawn Day Morales
Frederick Co. Dept. of Aging
1440 Taney Avenue
Frederick, MD 21702
301-600-1657
301-600-3554 FAX

Garrett County

Kathleen Kitty Stuart
Garrett County Area Agency on Aging
104 E. Center Street
Oakland, MD 21550-1328
301-334-9431 ext. 138
301-334-8555 FAX

Harford County

Mark Carroll
Harford County Office on Aging
145 N. Hickory Avenue
Bel Air, MD 21014
410-638-3025
410-893-8239 FAX

Howard County

Phyllis Braxton
Howard Co. Office on Aging
6751 Columbia Gateway Drive
Columbia, MD 21046
410-313-6495
410-313-5970 FAX

Upper Shore Aging

Kathleen Garson
Waiver Unit Manager
Upper Shore Aging, Inc
100 Schaubert Road
Chestertown, MD 21620
410-778-3621
410-778-3562 Fax

Washington County

Karin Escalante
Washington County
Commission on Aging
104 West Franklin Street
Hagerstown, MD 21740
240-420-2511